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ABSTRACT

The testimony provided in these hearings addresses the most fundamental problem facing older Americans today, i.e., economic security. The report discusses the results of expanding social services and income transfer programs to reduce poverty, and examines ways to increase older adults' economic self-sufficiency through expanded employment options and the Social Security systems. Federal health programs and long-term care issues, energy assistance programs, and social services are also discussed. Other topics covered in the report focus on housing, consumer issues, results of the White House Conference on Aging, crime, elder abuse, and lifelong learning. The appendices in part 2 contain supplementary reports from the Federal Council on Aging and various federal departments and agencies. (JAC)

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ED206996

97TH CONGRESS } SENATE { REPORT
1st Session } { No. 97-62

DEVELOPMENTS IN AGING: 1980

Part 1 and Part 2: Appendixes

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

PURSUANT TO

S. RES. 353, MARCH 5, 1980

Resolution Authorizing a Study of the Problems of the Aged and Aging

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LETTER OF TRANSMITTAL

U.S. Senate,
Special Committee on Aging,
Washington, D.C., May 13, 1981.

Hon. George Bush,
President, U.S. Senate,
Washington, D.C.

Dear Mr. President: Under authority of Senate Resolution 353, agreed to March 5, 1980, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1980, Part 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1980 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. During the second session of the 96th Congress, Senator Lawton Chiles served as chairman of the Special Committee on Aging. The preparation and writing of this report was largely accomplished during 1980 under Senator Chiles' leadership. I deeply appreciate that extensive contribution and his continuing cooperation in completing this important report.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

John Heinz, *Chairman.*

SENATE RESOLUTION 353, 96TH CONGRESS, 2D SESSION[1]

Resolved, That the Special Committee on Aging, established by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4 (legislative day, February 1), 1977, is authorized from March 1, 1980, through February 28, 1981, in its discretion to provide assistance for the members of its professional staff in obtaining specialized training, in the same manner and under the same conditions as a standing committee may provide such assistance under section 202(j) of the Legislative Reorganization Act of 1946, as amended.

Sec. 2. In carrying out its duties and functions under such section and conducting studies and investigations thereunder, the Special Committee on Aging is authorized from March 1, 1980, through February 28, 1981, to expend $342,600 from the contingent fund of the Senate, of which amount (1) not to exceed $25,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such act).

Sec. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than April 30, 1981.

Sec. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at annual rate.

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[1] Agreed to March 5, 1980.

PREFACE

Since 1900, the average life expectancy in America has increased by more than 25 years. While no one would want to change this triumph of survivorship, it is producing a rapid increase in the aged members of our population. By the year 2000, 31.8 million Americans—12 percent of the population—will be over the age of 65. This so-called "graying of America" may not be the demographic dilemma of the proportions predicted by some alarmists. However, it does have significant political, economic, and social implications and many of these issues will demand resolution in the coming decade.

Three decades of expanding social services and income transfer programs for the elderly have greatly improved their economic status. Older persons have made gains in both absolute and relative income levels so that the poverty rate for older persons dropped from 33 percent in 1950 to 14 percent in 1978.

Without the social security program, it is estimated that 60 percent of the older population would live in poverty. Furthermore, inkind benefit programs such as food stamps, subsidized housing, and medicaid increase the average income of those on low incomes by 81 percent for single persons and 68 percent for couples. The impact of noncash transfers thereby brings the effective poverty rate down considerably.

Nevertheless, the most fundamental problem confronting older Americans today is the issue of economic security in a time of high inflation.

In 1980, the public was beginning to realize the enormous significance of the issue of providing an adequate income for the retired population. Federal expenditures for income security—largely retirement and disability programs—represent one-half of the Federal budget and are generally regarded as uncontrollable items.

The growing number of older people and the strain put on these systems by high unemployment and high inflation raises serious questions about how the Nation will continue to provide adequate retirement income in the future.

The Senate Special Committee on Aging has examined ways to increase the economic self-sufficiency of the aged through expanded options for employment and ways to assure the financial soundness of the social security retirement program. It has explored how to meet the real needs of the aged population without imposing unnecessary dependency.

The inflation rate reached unprecedented levels during 1980, so that even with a portion of their income indexed for inflation, the overall incomes of older persons did not keep pace with rising prices. Energy bills alone consumed on the average 35 percent of the income of the low-income household. The return on prudent investments such as interest rates on small savings often did not keep pace with inflation.

The average annual increase in consumer prices during 1980 brought a 14.3-percent increase in social security checks and added almost $17 billion to the cost of the system.

Despite the expense of indexing benefit programs, median elderly incomes remained half those of younger persons. The 1979 poverty statistics revealed the rate had crept up to 15.1 percent from 14 percent the previous year—the first increase in the elderly poverty rate since 1975. Segments of the elderly population—notably minorities and women over the age of 75—were appallingly poor.

Elderly with reduced incomes found themselves paying much more for out-of-pocket medical expenses than younger families. Although Federal medicare payments totaled $41 billion, the program covered only about 38 percent of the elderly's medical bill.

At the same time the elderly, as a group, possessed great strength, resources, and assets—75 percent of older families owned their own homes, most of them, mortgage free. The elderly held approximately one-third of the Nation's personal savings. They comprised 11 percent of the population and paid about 10 percent of Federal income taxes. A larger percentage of the elderly had relatively high incomes than fell into the poverty category. Twenty percent of older families in 1979 had incomes above $20,000.

Almost 50 percent of elderly headed households reported some income from employment. Those who were employed had twice the average incomes of those who were not.

A number of trends which were emerging during 1980 appeared likely to set the pace for the early years of this decade.

Inflation, unless brought under control, threatened to put a permanent limitation on the ability of the Nation to meet its social goals.

Fiscal constraints required a more refined targeting of resources and a careful analysis of proposed new programs.

The escalating cost of health care and the fiscal solvency of social security loomed as the social policy and public expenditure issues of greatest significance to older persons.

Politicians, the public, and elderly persons themselves, continued to oppose age discrimination. It was recognized that while the aging process might sometimes result in poor health or lowered income status, age in and of itself should not be a barrier to anything.

With improvements in health and life expectancy, the older population represents a growing and invaluable source of experience and productivity.

To avoid unnecessary isolation, dependency, and unwelcome idleness; to seek a variety of opportunities for continued involvement; to strengthen individual choices and economic security in old age; these remained the challenge at the end of 1980.

JOHN HEINZ,
Chairman.
LAWTON CHILES,
Ranking Minority Member.

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EVERY NINTH AMERICAN

When we declared our independence, every 50th American was a so-called older person (aged 65 or over—65-plus). They came to some 50,000 out of an estimated total population of 2.5 million, or 2 percent.

By the beginning of this century, the numbers of older persons had increased much more rapidly than the young and they represented every 25th American (3.1 million or 4 percent of the 76 million total).

At the beginning of 1981, the over 25 million older Americans made up over 11 percent of the population—"Every Ninth American."[1]

But in recent years something uniquely different with new potentials for study and concern has become evident. In the past, the numbers of persons in all age groups increased even while the proportion of older persons in the population grew somewhat faster than did the younger age groups. Recent trends, however, have been different. Fertility rates since the end of the postwar baby boom have actually been below that necessary for zero population growth. A continuation of these trends over a lengthy period of time will bring us an aging society with an increasing median age and eventual declining total population by the middle of the 21st century.

Even cursory consideration indicates the enormous implications for retirement and income policies, the role of technology, the shifting of product markets and advertising, social and recreational facilities, location and types of housing, health care facilities and personnel, entertainment, etc.

What is the older population like, and how does it change?

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew almost threefold while the older part grew almost sevenfold.[2] The 65-plus population continues to grow faster than the under-65 portion: Between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population; for 1970–79, the increase was 23.5 percent for the 65-plus group but only 6.3 percent for the under 65.

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3), and New Mexico (37.7), all States with significant numbers of older in-migrants. These five States and Alaska also had the fastest growth rates (over 50 percent) in 1970–79: Nevada (96.6 percent), Arizona (79.5), Florida (62.7), Hawaii (59.9), New Mexico (54.8), and Alaska (54.2).

---

[1] This chapter has been prepared by Herman B. Brotman, consultant to the Special Committee on Aging, U.S. Senate, and former Assistant Commissioner on Aging, Department of Health, Education, and Welfare.

[2] Computed from reports of the 1900, 1960, and 1970 census enumerations, and estimates for 1979 prepared by the Census Bureau, using the 1970 counts as a base, and published in Current Population Reports.

Florida still has the highest proportion of older people—18.1 percent in 1979, 14.5 in 1970. Alaska remains the State with the smallest number and the smallest proportion of older persons—10,000 or 2.6 percent in 1979.

STATE HIGHLIGHTS

In mid-1979, the largest concentrations of older persons—13 percent or more of a State's population—occurred in six States: Florida (18.1), Arkansas (13.7), Iowa and South Dakota (13.1), Missouri and Nebraska (13).

California and New York each had more than 2 million older people, while Florida, Pennsylvania, Texas, Illinois, and Ohio each had more than 1 million.

Almost a quarter of the Nation's older people lived in just three States (California, New York, and Texas). Adding five more States (Pennsylvania, Illinois, Ohio, Michigan, and Florida) brings the eight-State total to almost half the older population of the United States. It takes 12 more States (New Jersey, Massachusetts, North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, and Louisiana) or a total of 20 States to account for just over three-quarters of the older population. It requires an additional 10 States or a total of 30 to include 90 percent. The remaining 10 percent of the 65-plus population lives in the remaining 20 States and the District of Columbia. (See exhibit A, "Recent State Trends in the Older Population, 1970–79," for the actual figures and a detailed analysis.)

TURNOVER

The older population is not a homogeneous group nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,400 persons aged 65-plus die.[3] The *net* increase is about 1,600 per day or almost 600,000 per year, but the 5,000 "newcomers" each day are quite different from and have experienced a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War.

AGE

As of mid-1980, most older Americans were under 75 (62.2 percent). Over half were under 73. And more than a third (34.9 percent) were under 70. Over 2.2 million Americans were 85 years of age or over.[4] As a result of the significantly longer life expectancy for females, the preponderance of women over men increases with age. (See "Sex Ratios" and "Projections.")

Accurate data on the number of centenarians are not available but 12,937 persons were receiving cash social security benefits in June

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[3] Computed from Census Bureau estimates of the components of population change.

[4] Computed from Census Bureau estimates in the Current Population Reports series, from National Center for Health Statistics reports on mortality and life expectancy in the Monthly Vital Statistics Reports series, and from estimates of centenarian beneficiaries supplied by the Social Security Administration.

1979, after producing some "proof of age" that indicated that they were then aged 100-plus. Further, sample studies of the file of persons covered by medicare produced an estimate of some 14,000 centenarians.

PERSONAL INCOME

Older economic units continue to have about half the income of their younger counterparts.[5] Retirement from the labor force usually brings a half to two-thirds cut in income and thrusts many older persons into a low-income category. Price inflation continues to present severe difficulties for older persons. Despite indexing of social security and some other benefit systems, much of the income of the elderly comes from sources which are not indexed, such as most private pension plan payments, commercial annuities, certain investments, such as bonds, and so forth.

Families

In 1979, half of the 8.8 million families headed by an older person had incomes of less than $11,316 ($218 a week) as compared with $21,201 ($408 a week) for the 49.6 million families with under-65 heads. Both medians represent an increase of about 11.5 percent over 1978, matching the increase in the Consumer Price Index and indicating no real change in purchasing power.

The skewing of the income distribution for older families toward the lower income levels is confirmed by the fact that the arithmetic average (mean) income of $14,730 is more than $3,400 or 30.2 percent greater than the median, $11,316, reflecting the impact of the high-income older families.

Thus, while the poverty rate for older families is high (see below), many have high incomes. More than 640,000 or 7.2 percent of older families had 1979 incomes of between $20,000 and $25,000; 1,010,000 or 11.5 percent had incomes between $25,000 and $50,000; and 182,000 or 2 percent had incomes in excess of $50,000. In summary, some 20 percent of the older families had higher incomes in 1979 than the median for younger families.

The importance of income from work (earnings) is shown by the fact that the 694,000 older families (7.9 percent of the total older families) whose heads were fully employed all year had double the median income of all older families ($22,852 versus $11,316) and almost double the mean income ($29,022 versus $14,730).

Unrelated Individuals

The 1979 median income of the 7.7 million unrelated individuals aged 65-plus who were living alone or with nonrelatives was $4,653 ($89 a week) as compared with $9,706 ($187 a week) for the 17.9 million aged 14 through 64 years old. The mean (arithmetic average) income for the older individuals was $6,541 or almost $1,900 or 40.6 percent higher than the median. Purchasing power, as compared with 1978, increased for the younger but decreased for the older individuals.

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[5] Computed from data collected by the Census Bureau in the March 1980 monthly Current Population Survey on money income in 1979 and published in preliminary Current Population Reports. Detailed data (such as by type of family, by source of income, etc.) is not yet available.

Slightly over 1 million or 14.3 percent of the older unrelated individuals had 1979 incomes of $10,000 or more; and, of these, 150,000 or 2.1 percent of all older individuals had $25,000 or more.

Poverty

(This analysis is based solely on cash money income and excludes consideration of services or noncash benefits and their impact on standard of living.)

In 1979, the total number of persons of all ages living in households in which the total income was below the official poverty threshold for that size and type of household rose to 25.2 million (11.6 percent of the U.S. population) from 24.5 million (11.4 percent) in 1978. Some 3.6 million older persons (15.1 percent or about a seventh of the 65-plus population) were poor by the official definition (for example, $4,364 for a household of an older couple or $3,472 for an older individual living alone). The increase in the number of aged poor over 1978, when they numbered 3.2 million or 14 percent, was the first increase since 1975.

Women and minority elderly are heavily overrepresented among the aged poor, according to 1979 census data:

POVERTY RATES (PERCENT OF OLDER PERSONS IN EACH SEX, RACE, OR SPANISH ORIGIN CATEGORY LIVING IN POOR HOUSEHOLDS)

Sex	Total	White	Black	Spanish origin[1]
Both sexes	15.1	13.2	35.5	26.7
Male	11.1	9.5	26.9	23.8
Female	17.9	15.8	41.7	29.1

[1] May be of any race.

Nevertheless, this is a significant improvement over the 4.7 million or a quarter of the elderly who lived in "poor" households in 1970 and results primarily from the increases in social security benefits. It must also be recognized that many of the aged poor became poor after reaching these age levels because of the half to two-thirds cut in income that comes with retirement from the labor force. Cost reductions after retirement are usually considerably less than the income loss.

Application of a somewhat more liberal standard of low-income status, 125 percent of the official poverty threshold (used as an eligibility criterion in some programs) in 1979 produces an estimate of 35.4 million persons of all ages (16.3 percent of the total population) and a disproportionately larger 5.9 million 65-plus persons (24.7 percent of the elderly) who fall below this standard (for example, $5,455 for an older couple household and $4,340 for an older individual living alone).

Adequacy—The Retired Couple Budget

In the early 1960's, the Bureau of Labor Statistics, with the help of a group of experts, developed a theoretic retired couple budget to provide a modest but adequate standard of living for a retired couple consisting of a 65-plus husband and his wife, assumed to be self-supporting and living in an urban area, to be in reasonably good health and able to take care of themselves, and to own a reasonable inventory of furniture and equipment.

Before 1969, the annual cost of the budget was calculated by actually pricing out all of the items in the budget and applying the appropriate "weighting." Since 1969, the cost of the budget is determined by applying to the cost for each division or component in the previous year the change in the comparable component of the Consumer Price Index for the urban wage earners and clerical workers. This procedure produces an approximation of unknown accuracy since spending patterns in the two measures are different as are the weights.

In 1979, the "intermediate" retired couple budget cost $8,562 ($165 a week). Of the 6.1 million two-person husband-wife families with 65-plus heads, about 2.2 million or 36 percent had less than this amount of income.

The cost of the lower budget, $6,023 ($116 a week), providing a reduced standard of living but well above the poverty level, could not be met by 1.1 million or 18.3 percent of these older couples.

The cost of the higher budget, $12,669 ($244 a week), providing some "luxury" items, gifts, contributions, and taxes, was beyond the income of 3.8 million or 62 percent of the 6.1 million older couples.[6]

INCOME MAINTENANCE

Old-Age, Survivors, and Disability Insurance

In July 1980, cash social security payments were sent to 35.1 million persons of all ages for a total of almost $10.5 billion.[7]

Of this total for the month, almost 30.4 million retired workers and their dependents or survivors received $9.2 billion from the old-age and survivors insurance trust fund, as follows:

	Number (thousands)	Amount (millions)
Retired workers	19,221	$6,510
Wives and husbands	2,992	511
Children	3,201	696
Widowed mothers	561	136
Widows and widowers	4,365	1,339
Parents (sole survivor)	15	4

And just under 100,000 special age-72 beneficiaries received $10.4 million.

Also, in July 1980, 4.7 million under-65 disabled workers and their dependents received almost $1.3 billion from the disability trust fund, as follows:

	Number (thousands)	Amount (millions)
Disabled workers	2,861	$1,059
Wives and husbands	467	52
Children	1,363	149

---

[6] Data on budget costs from bulletins of the Bureau of Labor Statistics. Number of couples within budget cost levels computed from unpublished Census Bureau data on 1979 money income, scheduled for later publication.

[7] Computed from data in selected issues of the monthly Social Security Bulletin and the Annual Statistical Supplements of the Social Security Administration.

Average monthly benefit, July 1980

Retired workers and their dependents:	
Retired workers[1]	$338.69
Wives and husbands	170.66
Children	137.03
Survivors of deceased workers:	
Children	236.90
Widowed mothers	242.27
Widows and widowers	306.73
Parents (sole survivor)	274.79
Disabled workers and their dependents:	
Disabled workers	370.04
Wives and husbands	110.54
Children	109.58
Special age-72 beneficiaries	104.37

[1] Almost 60 percent of all retired workers are receiving "reduced benefits" since they started drawing social security payments prior to reaching age 65. They represent a combination of voluntary "early retirements" and "discouraged workers" who have been unemployed and believe they cannot find employment.

BENEFICIARIES, BY AGE, JULY 1980

	Number (millions)	Percent distribution
All ages	35.1	100.0
Under 62	8.2	23.2
62 and over: Total	27.0	76.8
Retired workers	19.2	54.7
Disabled workers	.6	1.7
Dependents and survivors	7.0	20.1
Special age-72	.1	.3
62 to 64: Total	3.5	10.1
Retired workers	2.0	5.7
Disabled workers	.6	1.7
Dependents and survivors	.9	2.7
65 and over: Total	23.4	66.7
Retired workers	17.2	49.0
Dependents and survivors	6.1	17.4
Special age-72	.1	.3

During the month (July 1980), medicare disbursements totaled $2,986 million, of which $2,068 million, or close to 70 percent, was paid out under hospital insurance and $918 million under supplementary medical insurance. (See "Personal Health Care Expenditures.")

STATUS OF SOCIAL SECURITY INSURANCE TRUST FUNDS, JUNE 1980

[In millions of dollars]

Item	Old-age and survivors	Disability	Hospital	Supplementary medical
Receipts and interest	$6,655	$1,886	$3,075	$983
Payments	9,595	1,218	2,050	841
Administrative costs	84	29	38	43
Assets, end of month	27,515	7,507	14,678	4,657

As of the beginning of 1981, both the tax rate on covered earnings and the maximum amount of taxable wages are increased. (See further discussion of the social security program in chapter 3.)

Supplemental Security Income

In 1974, the Federal supplemental security income (SSI) needs-tested program replaced Federal-State assistance. The program sets up Federal payments to the aged, the blind, and the disabled, based on Federal eligibility and payment standards with automatic adjustments for increases in the Consumer Price Index.

States are encouraged to establish State supplement programs under their own laws and may then choose (1) to have the Federal Government pay the Federal payment and the State supplement in a single check to recipients in that State and bill the State for such supplementary payments, or (2) to make State payments separately to their own residents whether or not they receive Federal payments.

In July 1980, the Federal Government sent checks to 1,840,000 needy "aged" (65-plus) persons, totaling over $167,000,000 of Federal payments. An estimated additional 25,000 65-plus persons qualified for SSI as "blind" and 372,000 as "disabled"—both providing higher payment levels than for the "aged." Thus, while there were some 3.6 million older persons living in households where the income was below the poverty level in 1979, SSI payments were made to a total of 2.2 million.

In the 27 States which have arranged for the Federal Government to administer the State supplement, the combined checks went to some 1,205,000 65-plus persons and the State supplements totaled $69,118,000. The combined payments averaged a low of $73.10 in Maine to a high of $209.97 in California.

In the 23 States in which the State makes its supplementary payments directly to the recipient (a separate check in addition to the Federal payment), there were a total of 484,000 Federal recipients but only 138,400 State supplements totaling $9,613,000, averaging $69.45 per State recipient.

In the one State that pays no State supplement (Texas), Federal payments went to 150,000 "aged" recipients.

Seventeen States made State payments in July 1980 to 31,400 older persons who were not receiving Federal payments. These States paid out $2,495,000 or an average of $79.36.

HEALTH

National Health Expenditures

(Note: Includes personal health care, prepayment and administrative costs, governmental public health activities, and the costs of research and construction of medical facilities.)

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NATIONAL HEALTH EXPENDITURES, ALL AGES[1]

	Calendar year		
	1979	1978	1965
Total:			
Amount (billions of dollars)	212.2	188.6	42.0
Per capita (dollars)	942.94	845.53	212.32
Percent of gross national product	9.0	8.9	6.1
Private sources:			
Amount (billions of dollars)	120.8	108.0	31.0
Per capita (dollars)	536.82	483.88	156.84
Percent of total	56.9	57.2	73.9
Public sources:			
Amount (billions of dollars)	91.4	80.7	11.0
Per capita (dollars)	406.12	361.64	55.48
Percent of total	43.1	42.8	26.1
Type of expenditure:			
Amount (billions of dollars):			
Total	212.2	188.6	42.0
Personal health care	188.6	166.6	36.0
Prepayment and administration	7.7	7.2	1.7
Government public health activities	6.1	5.3	0.8
Research	4.6	4.3	1.5
Construction of medical facilities	5.3	5.2	2.0
Percent distribution:			
Total	100.0	100.0	100.0
Personal health care	88.9	88.3	85.7
Prepayment and administration	3.6	3.8	4.1
Government public health activities	2.9	2.8	1.9
Research	2.2	2.3	3.4
Construction of medical facilities	2.5	2.8	4.8

[1] Computed from data and estimates prepared by the Health Care Financing Administration.

Between the years 1965 (before medicare became effective) and 1979, the total health bill rose from $42 billion (6.1 percent of the GNP) to $212.2 billion (9 percent of the GNP). This quintupling of total costs in 14 years results from technological changes, very rapid increases in prices and labor costs, the impact of the growth and "aging" of the older population, and increased utilization made possible by increased resources, especially through public programs. Nursing home, hospital, and physician costs, all exceptionally important to health care of the elderly were among the most rapidly rising areas.

Personal Health Care Expenditures

(Note: Excludes prepayment and administrative costs, cost of research and construction of medical facilities, and governmental public health activities such as control of contagious diseases.)

Total personal health care expenditures rose from $37.3 billion or $138.43 per capita in 1965 to $167.9 billion or $752.98 per capita in 1978. The estimate for 1979 is $188.6 billion but age distributions are not yet available. It is estimated that if the 1979 figure were adjusted for price increases the 13.2 percent increase over 1978 would be reduced to 3.6 percent.

For the 65-plus population, total health care costs came to $49.4 billion; for the under-65, it came to $118.5 billion. On a per capita basis, however, the $2,026.19 for an older person was 3.4 times the $596.82 for an under-65 individual. Of the $49.4 billion for older persons, $18.2 billion or 37 percent came from private funds and $31.2 billion or 63 percent from public programs. Of the total public outlays, $26.8 billion or 86 percent came from Federal programs and $4.4 billion or 14 percent from State and local programs.

ANALYSIS OF PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE, SOURCE OF FUNDS, AND AGE GROUP, 1978

Type of expenditure	All ages	Under 65	65 and over						
						Public			
				Total	Private		Total	Federal	State/loca
Amount (total, millions of dollars)	167,911	118,545		49,366	18,192		31,175	26,780	4,395
Hospital care	76,025	54,856		21,169	2,645		18,524	17,165	1,359
Physicians' services	35,250	26,340		8,910	3,620		5,290	5,120	170
Dentists' services	13,300	11,917		1,383	1,338		45	28	17
Other professional services	4,275	3,185		1,090	631		459	421	38
Drugs and drug sundries	15,098	11,867		3,231	2,728		503	264	239
Eyeglasses and appliances	3,879	3,274		605	405		201	199	2
Nursing home care	15,751	3,127		12,624	6,790		5,834	3,336	2,498
Other health services	4,333	3,979		354	35		319	247	72
Per capita (total, dollars)	752.98	596.82		2,026.19	746.68		1,279.55	1,099.16	180.39
Hospital care	340.93	276.17		868.86	108.56		760.30	704.52	55.78
Physicians' services	158.08	132.61		365.70	148.58		217.12	210.15	6.98
Dentists' services	59.64	60.00		56.76	54.92		1.85	1.15	.70
Other professional services	19.17	16.03		44.74	25.90		18.84	17.28	1.56
Drugs and drug sundries	67.70	59.74		132.61	111.97		20.64	10.84	9.81
Eyeglasses and appliances	17.40	16.48		24.83	16.62		8.25	8.17	.08
Nursing home care	70.64	15.74		518.14	278.69		239.45	136.92	102.53
Other health services	19.43	20.03		14.53	1.44		13.10	10.14	2.96
Percent distribution by type of expenditure (total)	100.0	100.0		100.0	100.0		100.0	100.0	100.0
Hospital care	45.3	46.3		42.9	14.5		59.4	64.1	30.9
Physicians' services	21.0	22.2		18.0	19.9		17.0	19.1	3.9
Dentists' services	7.9	10.0		2.8	7.4		0.1	0.1	0.4
Other professional services	2.5	2.7		2.2	3.5		1.5	1.6	0.9
Drugs and drug sundries	9.0	10.0		6.5	15.0		1.6	1.0	5.4
Eyeglasses and appliances	2.3	2.8		1.2	2.2		0.6	0.7	----
Nursing home care	9.4	2.6		25.6	37.3		18.7	12.5	56.8
Other health services	2.6	3.4		0.7	0.2		1.0	0.9	1.6
Percent distribution by source of funds and age (total)	100.0	70.6	29.4	100.0	36.9	63.1	100.0	85.9	14.1
Hospital care	100.0	72.2	27.8	100.0	12.5	87.5	100.0	92.7	7.3
Physicians' services	100.0	74.7	25.3	100.0	40.6	59.4	100.0	96.8	3.2
Dentists' services	100.0	89.6	10.4	100.0	96.7	3.3	100.0	62.2	37.8
Other professional services	100.0	74.5	25.5	100.0	57.9	42.1	100.0	91.7	8.3
Drugs and drug sundries	100.0	78.6	21.4	100.0	84.4	15.6	100.0	52.5	47.5
Eyeglasses and appliances	100.0	84.4	15.6	100.0	66.8	33.2	100.0	99.0	1.0
Nursing home care	100.0	19.9	80.1	100.0	53.8	46.2	100.0	57.2	42.8
Other health services	100.0	91.8	8.2	100.0	9.9	90.1	100.0	77.4	22.6

Hospital care was the largest item by far in health care of older persons. The $21.2 billion ($868.86 per capita) for hospital payments used 43 percent of the total expenditures. Some $18.5 billion or almost 88 percent of these hospital payments came from public programs (of which 93 percent were Federal funds).

The next largest expenditure for older persons, nursing home care in 1978, came to $12.6 billion or $518.14 per capita (as compared with $4.1 billion or $204.87 per capita in 1970). The 1978 figure represents almost 26 percent of the total health bill for older persons, with 46 percent paid by public agencies (of which 57 percent was Federal money and 43 percent State and local).

The third largest expenditure, physicians' services, totaled $8.9 billion or $365.70 per capita. This was 18 percent of total expenditures for older persons; 60 percent was paid by public programs, 97 percent of which was Federal.

The other five categories of expenditures each accounted for less than 7 percent of the total. Noteworthy is the fact that in four (dentists' services, other professional services, drugs and drug sundries, and eyeglasses and appliances) of the five categories (fifth is other health services) private payments accounted for between 58 and 97 percent of the costs, reflecting to a very large extent the fact that these services and supplies are not usually provided by public programs.

Data for a comparison of levels and sources of payments that indicate the role of direct out-of-pocket, insurance, and philanthropic sources on a per capita basis for 1966 (the year medicare became effective) and a recent year are not yet available. The following presents unrevised data from last year's version of "Every Ninth American":

Age and fiscal year	Total	Direct out-of-pocket	Third-party payments			
			Total	Government	Private health insurance	Philanthropy and industry
Amount:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1977	514	164	350	150	187	13
65-plus:						
1966	445	237	209	133	71	5
1977	1,745	462	1,283	1,169	101	12
Distribution (percent):						
Under 65:						
1966	100	51.1	48.9	19.4	27.3	2.2
1977	100	31.9	68.1	29.1	36.4	2.6
65-plus:						
1966	100	53.2	46.8	29.8	15.9	1.1
1977	100	26.5	73.5	67.0	5.8	.7

This comparison shows both a significant increase in utilization as well as a doubling of health care prices, with a pronounced shift toward third-party payment arrangements, especially through public programs. The nominal dollar increase in out-of-pocket payments by older persons loses significance if allowance is made for the rapid price increases for the same amount of care plus the actual increase in utilization.

XXIII

EXPENDITURES BY PUBLIC PROGRAMS IN PERSONAL HEALTH CARE FOR PERSONS AGED 65 AND OVER, BY PROGRAM, 1978

[In millions of dollars]

Program	Total	Federal	State/local
Total	31,175	26,780	4,395
Medicare	21,775	21,775	0
Medicaid	6,611	3,684	2,927
Other medical public assistance	391	0	391
Veterans' Administration	1,053	1,053	0
Department of Defense	131	131	0
Workers compensation	93	4	89
State and local hospitals (net)	942	0	942
All other	182	136	46

Older persons comprised slightly over 11 percent of the total population in 1978 but accounted for 29.4 percent of the personal health care costs. Some 63 percent of the total payments for persons 65-plus came from public programs with 91 percent coming from medicare (69.8) and medicaid (21.2).

Health Status

In a recent household interview survey of a sample of the noninstitutionalized population, over two-thirds (69 percent) of the older persons reported their health good or excellent as compared with "others of their own age." Almost 22 percent reported their health as fair and 9 percent as poor. Minority group members, residents of the south, residents of nonmetropolitan areas, and persons with low incomes were more likely to report themselves in poor health.[8]

Counting the approximately 5 percent of older people who live in institutions as being in poor health, a total of about a seventh (14 percent) of all older people consider themselves in poor health.

In 1979 (based on the new Ninth Revision of the International Classification of Diseases), the most frequently reported chronic conditions reported by the noninstitutionalized elderly were: Arthritis (44 percent), hypertension (39 percent), hearing impairment (28 percent), heart conditions (27 percent), and visual impairments and arteriosclerosis (each about 12 percent).

In the 1979 survey, almost half (46 percent) of the 65-plus respondents said they had some limitation on their "usual" activity because of a chronic condition. About 17 percent were unable to perform their usual activity at all, 22 percent reported limitation in the amount or kind of usual activity, and about 7 percent were limited outside the usual activity.

A 1977 study showed that of the over 22 million older persons not in institutions, 2.1 percent were confined to bed, 2.6 percent needed help to get about in the house, 6 percent needed help to get about in the neighborhood and 8.4 percent needed help outside the neighborhood. In terms of needing help in daily functions, 3.8 percent needed help with bathing, 2.6 percent needed help with dressing, 0.8 percent with eating, and 1.4 percent with toilet. (See the table below for a crosstabulation of these two kinds of "helps" and an analysis of the differences by age groups within the 65-plus population. This is especially significant in view of the current concern over long-term or continuing care and the rapid growth in the oldest part of the older population, since the need for both types of "helps" increases markedly with age.)

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[8] Computed from published and unpublished data supplied by the National Center for Health Statistics, based on the Household Interview Survey, the Hospital Discharge Survey, the Nursing Home (Health Facilities) Survey, etc.

IMPACT OF DISABILITY RESULTING FROM CHRONIC CONDITIONS, PERSONS AGED 65 AND OVER, 1977

[Numbers in thousands]

Help needed	Noninstitutional population	Confined to bed	Needs help		
			In house	In neighborhood	Outside neighborhood
65-plus:					
Total	22,266	459	573	1,331	1,862
Percent	100.0	2.1	2.6	6.0	8.4
Percent [1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	853	302	494		
Percent [1]	3.8	65.9	77.4		
Dressing	582	249	371		
Percent [1]	2.6	54.3	64.6		
Eating	186	115	150		
Percent [1]	0.8	25.0	26.1		
Toilet	318	183	273		
Percent [1]	1.4	39.9	47.6		
65 to 74:					
Total	14,259	204	202	447	649
Percent	100.0	1.4	1.4	3.1	4.6
Percent [1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	293	117	161		
Percent [1]	2.1	57.2	80.0		
Dressing	215	101	143		
Percent [1]	1.5	49.9	70.8		
Eating	73	38	59		
Percent [1]	0.5	18.4	29.1		
Toilet	123	72	107		
Percent [1]	0.9	35.3	52.8		
75 to 84:					
Total	6,652	173	225	554	799
Percent	100.0	2.6	3.4	8.3	12.0
Percent [1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	355	117	166		
Percent [1]	5.3	67.4	73.9		
Dressing	238	86	132		
Percent [1]	3.6	49.7	58.8		
Eating	59	38	47		
Percent [1]	0.9	22.2	21.0		
Toilet	105	51	90		
Percent [1]	1.6	29.6	39.9		
85-plus:					
Total	1,355	81	146	331	414
Percent	100.0	6.0	10.8	24.4	30.6
Percent [1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	205	69	116		
Percent [1]	15.1	84.6	79.0		
Dressing	129	61	95		
Percent [1]	9.5	75.5	65.2		
Eating	53	39	44		
Percent [1]	3.9	47.8	30.0		
Toilet	91	60	77		
Percent [1]	6.7	73.3	52.4		

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[1] Percent of column total for this age group.

Utilization

Older people are subject to more disability, see physicians about 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Still, some 82 percent reported no hospitalization in the previous year.

In 1978, the average length of stay in a short-stay hospital for persons with one or more hospital stays was 7 days for all ages and 10.4 for those 65 and over. Averaging together those with hospital stays and the vast majority with no stays, the average number of hospital days was 1.9 for ages 55–64, 3.2 days for ages 65–74 and 6 days for those 75-plus. Using the same averaging approach for persons with and without nursing home stays, a 1976 survey showed a fraction of 1 day in a nursing home for persons aged 55–64, 4.4 days for those aged 65–74, a jump to 21.5 days for those aged 75–84 and to 86.4 days for the 85-plus.

Of the 1.1 million older people in nursing homes at the time of a 1977 study, 19 percent were aged 65–74, 41 percent were 75–84, and 40 percent were 85-plus—in the total older population, the comparable percentages were 62, 29, and 9. In the nursing home population, 74 percent were women (60 percent in the total older population), 69 percent were widowed, 14 percent were single, and 12 percent were married; 93 percent were white. Of every 100 residents in nursing homes, almost 40 came from their own residences (only 14 had been living alone), 32 came from general hospitals, 13 from other nursing homes or related facilities, and the rest (about 15) came from a variety of mental and other health facilities.

SELECTED DATA FROM THE 1979 HOUSEHOLD SURVEY OF THE NONINSTITUTIONAL POPULATION

	All ages	65-plus
Restricted-activity days per person per year	19.0	41.9
Bed-disability days per person per year	6.7	13.7
Number of acute conditions per person per year	2.2	1.1
Number of physician visits per person per year:		
Total	4.7	6.3
In doctor's office, clinic, or group practice	3.2	4.6
In hospital outpatient department or emergency room	.6	.7
By telephone	.6	.7
Interval since last physician visit (percent distribution of persons):		
Less than 1 yr	75.1	79.8
Under 6 mo	58.5	69.4
6 to 11 mo	16.5	10.4
1 yr	10.9	5.7
2 to 4 yr	9.3	7.8
5-plus yr	3.5	5.9
Never	.2	.1
Number of dental visits per person per year	1.7	1.4
Interval since last dental visit (percent distribution of persons):		
Less than 1 yr	50.2	32.8
Under 6 mo	35.6	24.4
6 to 11 mo	14.5	8.4
1 yr	13.1	7.6
2 to 4 yr	12.7	13.7
5-plus yr	13.6	43.7
Never	9.1	.7
Short-stay hospital discharges per 100 persons per year	13.9	27.0
Average length of stay (days)	7.8	10.8
Number of hospital episodes per year (percent distribution of persons):		
None	89.7	81.8
1 episode	8.5	13.9
2 episodes	1.3	3.0
3-plus episodes	.5	1.3
Average length of stay for persons with hospital stays by number of episodes:		
Total, all episodes	9.6	14.3
1 episode	6.6	10.1
2 episodes	17.5	22.2
3-plus episodes	37.6	40.4

Death Rates

Death rates for every age group and both sexes have been declining since 1950 except for 15 to 24-year-old males.[9] Between 1977 and 1978, death rates declined except for males aged 1–4, females aged 5–9, and both males and females aged 15–24 and 75–84.

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[9] Computed from mortality data prepared by the Vital Statistics Division of the National Center for Health Statistics and based on the death certificate reporting system.

In the period between 1965 and 1978, annual death rates for older persons dropped about 12 percent from 6 per 100 to 5.3 per 100. Within the older population, the rate for persons 65–74 dropped 19 percent from 3.7 to 3.1 per 100, the rate for those 75–84 declined 14 percent from 8.4 to 7.2 per 100, while the rate for the 85-plus dropped 27 percent from 20.1 to 14.7 per 100.

The rate for deaths of older persons from heart disease dropped 18 percent, from 2.8 to 2.3 per 100. The death rate from stroke fell 33 percent, from 0.9 to 0.6 per 100 but the rate for deaths from cancer increased 11 percent, from 0.9 to 1. These declines in death rates accelerated the more recent increases in life expectancy in the upper ages.

Heart disease, stroke, and cancer accounted for three-quarters of the deaths of older persons in 1978 as they did in 1965. The following table analyzes the number and proportion of deaths accounted for by the major causes of death in 1978 for all ages and for 10-year age groupings in the middle and upper age groups. Particularly noteworthy are the increasing proportions of deaths from heart disease and stroke with advancing age (also true at a lower level for influenza and pneumonia) but the sharp drop in the proportion of deaths caused by cancer. While accidental deaths have traditionally been most prevalent among the younger, the more recent increase in suicides among the very young have overshadowed the situation for the aged.

SELECTED MAJOR CAUSES OF DEATH IN 1978, ALL AGES AND AGE GROUPS OVER 45

Cause	Number (thousands)						Percent distribution [1]					
	All ages	45–54	55–64	65–74	75–84	85+	All ages	45–54	55–64	65–74	75–84	85+
All causes	1,928	141	293	452	497	324	100.0	100.0	100.0	100.0	100.0	100.0
Major cardiovascular diseases (total)	966	51	128	233	304	227	50.1	36.6	43.9	51.5	61.1	70.0
Diseases of the heart	730	44	108	184	221	156	37.8	30.9	36.8	40.7	44.4	48.2
Cerebrovascular diseases	176	6	15	36	63	50	9.1	4.5	5.2	8.0	12.7	15.5
Arteriosclerosis	29	([2])	1	4	10	14	1.5	.2	.3	.8	2.0	4.3
Other	32	1	4	9	10	6	1.7	1.0	1.6	2.0	2.0	2.0
Malignant neoplasms	397	43	91	120	90	32	20.6	30.2	31.2	26.4	18.0	9.9
Influenza and pneumonia	58	2	5	10	18	19	3.0	1.6	1.7	2.2	3.6	5.7
Diabetes mellitus	34	2	6	10	10	5	1.8	1.6	1.9	2.1	2.0	1.4
Accidents	106	9	10	9	9	6	5.5	6.5	3.3	2.0	1.8	1.9
Suicides	27	4	4	3	2	([2])	1.4	2.8	1.3	.6	.3	.1
All other	340	29	49	69	65	36	17.6	20.7	16.7	15.2	13.2	11.0

[1] Computed from numbers before rounding to nearest thousand.
[2] Less than 500.

HOUSING

The 1976 annual housing survey showed 14.8 million elderly households (households with heads aged 65-plus) and they constituted 20 percent of the total 74.1 million households in the United States.[20]

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[20] Basic data from special analyses of the Annual Housing Survey of the Department of Housing and Urban Development, from research organization retabulation of the survey data, and from selected administrative summaries of program activities.

Broad measures of housing conditions showed many similarities between the elderly and the younger households but there were differences in many of the details arising from the somewhat lower proportion of the elderly living in metropolitan areas, their concentration in the inner city, their generally lower income level, the greater age of their homes and the accompanying maintenance problems and costs, the presence of excess space as maturing family members leave their parents' homes, etc. In general, about 90 percent of housing was evaluated as "adequate."

The traditional rule of thumb is that housing should not cost more than 25 percent of income. In the 1976 survey, it was found that 80.3 percent of all households and only 58.7 percent of elderly households could "afford" adequate housing if they spent under 25 percent of their income. For owners, the percentages were 84.3 percent for all and 62.2 percent for the elderly; for renters, 72.8 and 50.1 percent. In fact, in 1976, 32 percent of all households spent more than 25 percent of their income for housing while 35 percent of the elderly did so—65 percent of renters and 23 percent of owners.

Homeownership is more prevalent among the aged than the younger households (70.6 versus 63.3 percent) and an estimated 84 percent of the elderly had paid off their mortgages completely.

The elderly tend to live in much older structures than do younger families. Almost 60 percent of the elderly households live in structures built before 1950 as compared with 40 percent for the younger. Prewar housing is occupied by 47.1 percent of the older households and only 30.2 percent of the younger.

While the totals for flawed or inadequate housing were rather similar (about 10 percent in each case), older households had more problems with plumbing, kitchens, and sewage, while the younger had more problems with maintenance and toilet access (the latter because of the presence of children under 18).

As expected, household income, value of owned home, and monthly rental are considerably larger for all households than for the older households; moreover, it must be remembered that some other costs, like food and health care, absorb larger proportions of the incomes of older households.

While older households, like all households, have about one chance in ten of being inadequately housed, black and Hispanic families have only one chance in five of enjoying adequate housing. In the worst case, a poor Hispanic man aged 65-plus and living alone has less than one chance in two (a probability of 0.56 as compared with 0.43 for a poor elderly black man).

XXVIII

COMPARISON OF CHARACTERISTICS OF HOUSEHOLDS WITH UNDER-65 AND 65-PLUS HEADS, 1976

[Percent distributions]

Characteristic	Heads under 65	Heads 65-plus	Characteristic	Heads under 65	Heads 65-plus
Total households	100.0	100.0	Total households	100.0	100.0
Tenure:			Type of heating equipment:		
Homeowner	63.3	70.6	Central	54.6	43.5
Cash rent	34.5	26.4	Steam	17.8	20.6
No cash rent	2.2	3.0	Electric	6.6	6.0
Year structure built:			Floor, wall	8.5	9.4
After March 1970	17.5	7.7	Room heater	5.4	9.5
1965 to 70	13.1	8.9	Other/inadequate	7.1	11.0
1960 to 64	11.1	7.5	Air-conditioning	53.8	46.6
1950 to 59	18.4	16.2	Alterations during year ($100 plus)	10.5	4.7
1940 to 49	9.6	12.6	Water source:		
1939 or earlier	30.2	47.1	Public or private	83.5	83.5
Units in structure:			Individual well	15.0	14.8
1	68.7	67.1	Other	1.5	1.7
2 to 4	12.4	12.8	Electricity:		
5 or more	13.9	15.1	Yes	99.8	99.8
Mobile home	5.0	4.9	No	.2	.2
Hotel or rooming house	.3	.5	Type of sewage disposal:		
Number of bathrooms:			Public sewer	73.1	73.2
None or shared	2.1	4.6	Septic tank/cesspool	25.9	24.4
1 but separated	.3	.6	Chemical toilet		
1	58.9	70.1	Privy	.9	2.0
1.5	14.9	11.9	Other	.1	.4
2	16.7	10.2			
3 or more	7.1	2.6			

CHARACTERISTICS OF HOUSEHOLDS WITH 65-PLUS HEADS, 1976

Characteristic	Number (thousands)			Percent distribution			Percent of total	
	Total	Metropolitan area	Nonmetropolitan area	Total	Metropolitan area	Nonmetropolitan area	Metropolitan area	Nonmetropolitan area
Total households	14,827	9,301	5,525	100.0	100.0	100.0	62.7	37.3
Tenure:								
Homeowner	10,469	6,118	4,352	70.6	65.8	78.8	58.4	41.6
Cash rent	3,913	2,990	923	26.4	32.1	16.7	76.4	23.6
No cash rent	445	194	251	3.0	2.1	4.5	43.6	56.4
Year structure built:								
After March 1970	1,142	721	421	7.7	7.8	7.6	63.1	36.9
1965–70	1,318	820	498	8.9	8.8	9.0	62.2	37.8
1960–64	1,109	708	401	7.5	7.6	7.2	63.8	36.2
1950–59	2,399	1,583	815	16.2	17.0	14.8	66.0	34.0
1940–49	1,876	1,224	653	12.6	13.2	11.8	65.2	34.8
1939 or earlier	6,983	4,245	2,737	47.1	45.6	49.5	60.8	39.2
Units in structure:								
1	9,951	5,431	4,519	67.1	58.4	81.8	54.6	45.4
2 to 4	1,905	1,441	464	12.8	15.5	8.4	75.6	24.4
5 or more	2,243	2,027	216	15.1	21.8	3.9	90.4	9.6
Mobile home	729	402	327	4.9	4.3	5.9	55.1	44.2
Hotel or rooming house	76	59	17	.5	.6	.3	77.6	22.4
Number of bathrooms:								
None or shared	680	221	459	4.6	2.4	8.3	32.5	67.5
1 bath but separated	93	76	18	.6	.8	.3	81.7	19.3
1	10,390	6,532	3,859	70.1	70.2	69.8	62.9	37.1
1.5	1,760	1,123	637	11.9	12.1	11.5	63.8	36.2
2	1,511	1,060	451	10.2	11.4	8.2	70.2	29.8
3 or more	392	290	102	2.6	3.1	1.8	74.0	26.0

CHARACTERISTICS OF HOUSEHOLDS WITH 65-PLUS HEADS, 1976—Continued

Characteristic	Number (thousands)			Percent distribution			Percent of total	
	Total	Metropolitan area	Nonmetropolitan area	Total	Metropolitan area	Nonmetropolitan area	Metropolitan area	Nonmetropolitan area
Type of heating equipment:								
Central	6,450	4,155	2,295	43.5	44.7	41.5	64.4	35.6
Steam	3,063	2,554	509	20.6	27.4	9.2	83.4	16.6
Electric	890	523	368	6.0	5.6	6.7	58.8	41.2
Floor, wall	1,394	874	520	9.4	9.4	9.4	62.7	37.3
Room heater	1,405	578	827	9.5	6.2	15.0	41.1	58.9
Other/inadequate	1,625	618	1,007	11.0	6.6	18.2	38.0	62.0
Air-conditioning	6,914	4,565	2,349	46.6	49.1	42.5	66.0	34.0
Alterations during year ($100 plus)	699	441	258	4.7	4.7	4.7	63.1	36.9
Water source:								
Public or private	12,385	8,612	3,773	83.5	92.6	68.3	69.5	30.5
Individual well	2,188	644	1,544	14.8	6.9	27.9	29.4	70.6
Other	253	45	208	1.7	.5	3.8	17.7	82.3
Electricity:								
Yes	14,796	9,291	5,505	99.8	99.9	99.6	62.8	37.2
No	31	10	21	.2	.1	.4	32.3	67.7
Type of sewage disposal:								
Public sewer	10,848	7,935	2,913	73.2	85.3	52.7	73.1	26.9
Septic tank/cesspool	3,622	1,302	2,319	24.4	14.0	42.0	36.0	64.0
Chemical toilet	7	4	3	----	----	----	----	----
Privy	294	45	248	2.0	.5	4.5	15.3	84.7
Other	57	15	42	.4	.2	.8	26.3	73.7

HOUSEHOLD INCOME, VALUE OF HOME, AND MONTHLY RENTAL, 1977

[Numbers in thousands]

Type of household	Owner occupied				Renter occupied			
	All ages		65-plus		All ages		65-plus	
	Number	Median	Number	Median	Number	Median	Number	Median
	Household income							
All households	48,765	$16,000	----	----	----	----	----	----
2-plus person households	42,088	17,600	----	----	17,395	$10,000	----	----
Husband-wife	36,274	18,500	5,551	$9,200	10,748	12,100	1,119	$7,100
Other male head	1,775	15,400	390	9,700	1,943	9,300	97	6,500
Female head	4,039	10,100	952	7,800	4,705	5,800	384	5,000
1-person household	6,677	5,800	----	----	9,119	6,300	----	----
Male head	1,998	9,600	748	5,100	4,048	8,600	724	4,100
Female head	4,680	4,900	2,988	4,300	5,071	4,900	2,080	3,700
	Value of home				Monthly rental			
All households	38,754	$36,900	----	----	----	----	----	----
2-plus person households	34,058	38,200	----	----	16,806	$197	----	----
Husband-wife	29,459	38,100	4,013	$32,500	10,239	201	1,060	$178
Other male head	1,344	36,400	301	28,900	1,908	217	92	154
Female head	3,254	30,500	738	26,200	4,608	184	374	149
1-person household	4,696	27,100	----	----	9,010	160	----	----
Male head	1,321	28,500	528	24,600	3,967	159	698	98
Female head	3,375	26,700	2,168	25,700	5,043	160	2,063	153

SUMMARY OF HUD ELDERLY HOUSING PROGRAM ACTIVITIES

ype of program and ection number of act	Program	Status	Number of projects	Number of units	Value (millions)	Estimated number of elderly units	Percent elderly units	Period covered
Construction:								
3, 4, title II	Low-income public housing	Active	10,750	1,200,000	NA	[1] 552,000+	46	Through Sept. 30, 1979.
202	Direct loans for housing for the elderly and the handicapped.	Inactive [2]	330+	45,275	$574.6	45,275	100	Through 1972.
		Active [3]	1,211	91,716	3,325.1	87,522	95	Through May 31, 1980.
231	Mortgage insurance for housing for the elderly	Active	477	64,116	1,083.0	64,116	100	Through Dec. 1979.
221(d)3	Multifamily rental housing for low- and moderate-income families.	do	3,417	346,383	5,337.5	55,602	7	Do.
221(d)4		do	3,874	447,938	8,938.9			Do.
235	Homeownership assistance for low- and moderate-income families.	Inactive [2]	[4] 472,059	473,032	8,456.7			Through revision.
		Active	40,862	40,883				Revision through May 1980.
207	Multifamily rental housing	do	2,639	285,108	3,937.7	3,421	1	Through Dec. 1979.
236	Rental and cooperative assistance for lower income families.	Inactive	4,052	434,645	7,480.0	53,799	12	Through Dec. 1978.
202/236	202/236 conversion	do	182	28,306	482.0	28,306	100	Do.
232	Nursing homes and intermediate care facilities	Active	1,271	145,262	1,581.6	145,262	100	Through Dec. 1979.
Nonconstruction:								
8	Low-income rental assistance:							
	Existing [5]	do	9,446	821,418	NA	240,742	29	Through May 31, 1980.
	New construction [5] [6]	do	8,393	538,561	NA	290,447	54	Do.
	Substantial rehabilitation [5] [6]	do	1,650	112,828	NA	40,107	35	Do.
312	Rehabilitation loans	do [7]	75,913	NA	780.2	NA	25	Through Sept. 30, 1979.
23	Low rent leased housing	Inactive [2]	NA	163,267	NA	54,000+	35+	Through Dec. 1975.

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[1] Number of units designed specifically for the elderly is not available.
[2] Figures for original program reported through program revision.
[3] Figures for revised sec. 202/8 represent cumulative project reservations as of May 31, 1980.
[4] Figures represent number of mortgages.
[5] Figures represent cumulative fund reservations through reporting date.
[6] Figures do not include sec. 8 commitments attached to sec. 202/8 fund reservations.
[7] Figures represent loan commitments only.

XXXI

LIFE EXPECTANCY

Life expectancy (average remaining years of life) reached new highs for the United States. The total for both sexes combined was 73.3 years but the 77.2 years for females was 7.7 years longer than the 69.5 for males.[11]

At age 65, the combined expectancy was 16.3 years with the 18.4 years for women exceeding by 4.4 years the remaining years for men, 14.

The 26-year or 55-percent increase in life expectancy at birth since 1900 (when it was 47.3) results to a large extent from the wiping out of most of the killers of infants and of the young. Only since midcentury has life expectancy in the upper ages begun to improve as death rates from the killers of older persons, chronic conditions and diseases, began to decrease. Thus, during the first half of this century, growing numbers of persons reached older ages but once there, did not live much longer than did their ancestors who reached such age. Since the 1950's, life expectancy at the upper ages has also increased and current decreases in death rates from cardiovascular conditions portend further added years of life.

The gap between whites and "others" (primarily black) in life expectancy at birth has narrowed in recent decades. Also, for those who do reach advanced age, about at the age of 70, life expectancy is slightly higher for those in the category "others" than for whites.

The tables below analyze in detail the changes in life expectancy by sex and color at selected ages for selected years between 1900 and 1980, the translation of these trends into estimates of the number of babies born in 1900 and 1978 expected to reach selected ages (for example, about 40 percent of babies born in 1900 were expected to reach age 65 as compared with 76 percent for 1978), and a listing of the 25 countries having the highest male and female life expectancies as reported by the United Nations.

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[11] Computed from basic data on mortality and life expectancy published by the Vital Statistics Division of the National Center for Health Statistics. Simulated projections prepared by the author.

XXXII

LIFE EXPECTANCY (AVERAGE REMAINING YEARS OF LIFE) AT SELECTED AGES, 1900-78

Age and year	Total			White			Other		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
At birth:									
1900	47.3	46.3	48.3	47.6	46.6	48.7	33.0	32.5	33.5
1910	50.0	48.4	51.8	50.3	48.6	52.0	35.6	33.8	37.5
1920	54.1	53.6	54.6	54.9	54.4	55.6	45.3	45.5	45.2
1930	59.7	58.1	61.6	61.4	59.7	63.5	48.1	47.3	49.2
1940	62.9	60.8	65.2	64.2	62.1	66.6	53.1	51.5	54.9
1950	68.2	65.6	71.1	69.1	66.5	72.2	60.8	59.1	62.9
1960	69.7	66.6	73.1	70.6	67.4	74.1	63.6	61.1	66.3
1970	70.9	67.1	74.8	71.7	68.0	75.6	65.3	61.3	69.4
1978	73.3	69.5	77.2	74.0	70.2	77.8	69.2	65.0	73.6
Increase 1900-78:									
Years	26.0	23.2	28.9	26.4	21.6	29.1	36.2	32.5	40.1
Percent	55.0	50.1	59.8	55.5	44.4	59.8	109.7	100.0	119.7
At age 20:									
1900					42.2	43.8	--------	35.1	36.9
1920					45.6	46.5	--------	38.4	37.2
1940					47.8	51.4	--------	39.7	42.1
1960					50.3	56.3	--------	45.8	50.1
1978	55.0	51.4	58.7	55.5	52.0	59.1	51.5	47.4	55.6
Increase 1900-78:									
Years					9.8	15.3	--------	12.3	18.7
Percent					23.2	34.9	--------	35.0	50.7
At age 45:									
1900					24.2	25.5	--------	20.1	21.4
1920					26.0	27.0	--------	23.6	22.6
1940					25.9	28.9	--------	22.0	24.0
1960					27.3	32.5	--------	24.9	28.1
1978	31.9	28.8	34.9	32.2	29.1	35.2	29.6	26.5	32.7
Increase 1900-78:									
Years					4.9	9.7	--------	6.4	11.3
Percent					20.2	38.0	--------	31.8	52.8
At age 65:									
1900					11.5	12.2	--------	10.4	11.4
1920					12.2	12.8	--------	12.1	12.4
1940					12.1	13.6	--------	12.2	14.0
1960					13.0	15.9	--------	12.8	15.1
1978	16.3	14.0	18.4	16.4	14.0	18.4	16.1	14.1	18.0
Increase 1900-78:									
Years					2.5	6.2	--------	3.7	6.6
Percent					21.7	50.8	--------	35.6	57.9
At age 75:									
1900					6.8	7.3	--------	6.6	7.9
1920					7.3	7.6	--------	7.6	8.4
1940					7.2	7.9	--------	8.1	9.8
1960					7.9	9.3	--------	8.9	10.1
1978	10.4	8.7	11.5	10.3	8.6	11.5	11.2	9.8	12.5
Increase 1900-78:									
Years					1.8	4.2	--------	3.2	4.6
Percent					26.5	57.5	--------	48.5	58.2
At age 85:									
1900					3.8	4.1	--------	4.0	5.1
1920					4.1	4.2	--------	4.5	5.2
1940					4.0	4.3	--------	5.1	6.4
1960					4.3	4.7	--------	5.1	5.4
1978	6.4	5.5	6.9	6.2	5.3	6.7	9.0	7.8	9.9
Increase 1900-78:									
Years					1.5	2.6	--------	3.8	4.8
Percent					39.5	63.4	--------	95.0	94.1

XXXIII

PERCENT OF BABIES BORN IN 1900 AND IN 1978 EXPECTED TO SURVIVE TO SELECTED AGES

Age and year	Total			White			Other		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
To age 20:									
1900					76.4	79.0		56.7	59.1
1978	97.5	97.1	98.0	97.7	97.3	98.2	96.6	96.1	97.2
Ratio 1978/1900					1.3	1.2		1.7	1.6
To age 45:									
1900					61.4	64.7		39.2	42.3
1978	93.3	91.3	95.3	94.0	92.2	95.8	89.0	85.3	92.4
Ratio 1978/1900					1.5	1.5		2.2	2.2
To age 65:									
1900					39.2	43.8		19.0	22.0
1978	75.9	68.3	82.6	77.5	71.0	83.9	65.0	56.4	73.4
Ratio 1978/1900					1.8	1.9		3.0	3.3
To age 75:									
1900					21.4	25.4		8.9	11.1
1978	55.4	44.7	66.1	57.0	46.2	67.8	44.0	34.4	53.9
Ratio 1978/1900					2.2	2.7		3.9	4.9
To age 85:									
1900					5.3	7.1		2.0	3.6
1978	25.9	16.5	35.5	26.6	16.8	36.6	20.5	13.8	27.9
Ratio 1978/1900					3.2	5.2		6.9	7.8

LIFE EXPECTANCY AT BIRTH, SELECTED COUNTRIES

[1977 United Nations Demographic Yearbook]

	Males			Females			
Rank	Country	Date	Years	Country	Date	Years	Rank
1	Japan	1976	72.15	Norway	1975–76	78.12	1
2	Sweden	1972–76	72.10	Sweden	1972–76	77.75	2
3	horway	1975–76	71.85	Japan	1976	77.35	3
4	Netherlands	1971–75	71.2	Netherlands	1971–75	77.2	4
5	Denmark	1975–76	71.1	France	1974	76.9	5
6	Israel	1975	70.3	Denmark	1975–76	76.8	6
7	Switzerland	1968–73	70.29	United States	1975	76.5	7
8	Spain	1970	69.69	Canada	1970–72	76.36	8
9	England and Wales	1974–76	69.62	Switzerland	1968–73	76.22	9
10	Canada	1970–72	69.34	Finland	1975	75.93	10
11	France	1974	69.0	England and Wales	1974–76	75.82	11
12	Italy	1970–72	68.97	Austria	1976	75.05	12
13	Germany, Democratic Republic	1969–70	68.85	Spain	1970	74.96	13
14	Ireland	1970–72	68.77	Italy	1970–72	74.88	14
15	United States	1975	68.7	Germany, Federal Republic	1974–76	74.81	15
16	Bulgaria	1969–71	68.58	New Zealand	1970–72	74.60	16
17	New Zealand	1970–72	68.55	Poland	1976	74.55	17
18	Cuba	1970	68.5	Belgium	1968–72	74.21	18
19	Germany, Federal Republic	1974–76	68.30	Germany, Democratic Republic.	1969–70	74.19	19
20	Austria	1976	68.07	Australia	1965–67	74.15	20
21	Belgium	1968–72	67.79	U.S.S.R	1971–72	74.0	21
22	Australia	1965–67	67.63	Israel	1975	73.9	22
23	Greece	1960–62	67.46	Bulgaria	1969–71	73.86	23
24	Finland	1975	67.38	Czechoslovakia	1977	73.6	24
25	Romania	1974–76	67.37	Ireland	1970–72	73.52	25

SEX RATIOS

As a result of the yet unexplained longer (and increasing) life expectancy for females as compared to males, most older persons are women—14.8 million women and 10 million men in mid-1980. Death rates are higher for males than for females at every age (including the fetus) so that although there are approximately 105 boy babies born for every 100 girl babies, the numbers at the same age even out by the end of the teens and then females outnumber males in ever larger numbers thereafter.

For the total 65-plus population, there are 147 women per 100 men. In the 65–74 age group, the ratio is 131, rising to 178 women per 100 men for those 75 and over. For the 85-plus group, there are 224 women per 100 men.[12] (See "Marital Status" and "Projections" below.)

MARITAL STATUS

In 1979, most older men were married (7.4 million or 77 percent) but most older women were widows (7.1 million or 52 percent). There are 5.3 times as many older widows as there are widowers. Among the 75-plus women, almost 70 percent were widows. About 35 percent of the married 65-plus men have under-65 wives.

MARITAL STATUS, BY SEX AND AGE GROUP, 1979

Sex and marital status	Numbers (thousands)				Percent distribution			
	45–54	55–64	65–74	75+	45–54	55–64	65–74	75+
Male: Total	11,036	9,744	6,385	3,163	100.0	100.0	100.0	100.0
Married	9,447	8,449	5,188	2,178	85.6	86.7	81.3	68.9
Not married	1,589	1,295	1,197	985	14.4	13.3	18.7	31.1
Single [1]	761	510	358	154	6.9	5.2	5.6	4.9
Widowed	194	328	591	759	1.8	3.4	9.2	24.0
Divorced	633	456	248	71	5.7	4.7	3.9	2.2
Female: Total	11,790	10,887	8,382	5,245	100.0	100.0	100.0	100.0
Married	9,402	7,629	4,090	1,150	79.7	70.1	48.8	21.9
Not married	2,388	3,258	4,292	4,095	20.3	29.9	51.2	78.1
Single [1]	520	504	504	324	4.4	4.6	6.0	6.2
Widowed	895	2,045	3,454	3,656	7.6	18.8	41.2	69.7
Divorced	972	709	335	113	8.2	6.5	4.0	2.2
Ratio: [2] Total	107	112	131	166				
Married	100	90	79	53				
Not married	150	252	359	416				
Single [1]	68	99	141	210				
Widowed	461	623	584	482				
Divorced	154	155	135	159				

[1] Never married.
[2] Number of women per 100 men.

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[12] Computed from estimates prepared by the Census Bureau based on the 1970 census enumeration and the monthly Current Population Surveys thereafter.

XXXV

The impact of differential life expectancies by sex may be illustrated by a theoretic application of life expectancies in 1978 to an assumed 100 marriages in 1980 where all grooms are aged 25 and all brides are aged 20, as follows:

Year	Age		Number expected to reach this age		Widows	
	Husband	Wife	Husband	Wife	Number	Percent
1980	25	20	100	100	0	0
1985	30	25	99	100	1	1
1990	35	30	98	99	1	1
1995	40	35	97	99	2	2
2000	45	40	95	98	3	3
2005	50	45	92	97	5	5
2010	55	50	88	96	8	8
2015	60	55	81	93	12	13
2020	65	60	72	90	18	20
2025	70	65	61	84	23	27
2030	75	70	47	77	30	39
2035	80	75	31	67	36	53
2040	85	80	17	53	36	68
2045	90	85	7	36	7	7

Note: In order to illustrate an extreme case, it was assumed that the male deaths were all among the married men with a spouse present while all of the female deaths were among the already widowed.

In 1978, there were approximately 2.3 million marriages of persons of all ages. The rate (number per 1,000 in the specific group who are theoretically eligible to marry) was 53.3 for females and 64.9 for males. As can be seen in the table below, the 2.3 million marriages included 19,800 65-plus brides and 37,600 65-plus grooms. The marriage rate for older grooms was almost 7 times that of the older brides (13.2 versus 2), partly because there are fewer males in these age groups and partly because men usually marry women younger than themselves. Approximately three-quarters of the older brides and grooms were previously widowed.

MARRIAGES OF PERSONS AGED 65 AND OVER IN 1978[1]

Previous marital status	Brides		Grooms	
	Number	Rate	Number	Rate
All marriages	19.8	2.0	37.6	13.2
First marriages	1.1	1.0	1.9	2.5
Remarriages	18.7	2.1	35.7	16.8
Previously widowed	15.5	1.8	27.3	15.6
Previously divorced	3.2	6.4	8.4	20.8

[1] Numbers in thousands. Rate is number per 1,000 in the specific group who are theoretically eligible.

EDUCATIONAL ATTAINMENT

In 1979, about half of all older Americans had less than a 10th grade education; the median for the 25–64 age group was high school graduation. About 2.1 million or 9 percent of the older people were "functionally illiterate," having had no schooling or less than 5 years. At the other end of the scale, about 8 percent were college graduates. The increasing educational attainment of the older population (an increase of more than a year of schooling in the median since 1970) results from a classic example of a cohort effect rather than the aging process; in the past, each succeeding generation has been given the opportunity to receive more schooling than did its predecessor—as each cohort with more years of schooling reaches age 65 and the oldest cohort with less schooling dies off, the median increases.

LIVING ARRANGEMENTS

In 1979, more than 8 of every 10 older men but less than 6 of every 10 older women lived in family settings. The others lived alone or with nonrelatives except for the one in twenty who lived in an institution (a figure that jumps to one in five in the 85-plus age group).

About three-quarters of the older men lived in families that included the wife but only slightly more than a third of the older women lived in families that included the husband. Four of every 10 older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1979, a smaller proportion of the older noninstitutionalized population lived in metropolitan areas than was true of the younger (63 versus 68 percent) but in a reversal of the previous pattern, more than half of the older people in metropolitan areas lived in the suburbs rather than the central city, primarily because of the shift in the larger metropolitan areas (over 1 million inhabitants). The preponderance of suburbanites among the under-65 population increased substantially so that 60 percent of the under-65 residents of metropolitan areas lived outside the central city.

Proportionately more older than younger people lived in nonmetropolitan areas with the largest concentrations in the smaller areas (containing no county with more than 2,500 inhabitants).

As may be seen from the summary table just below, the last column (Ratio) shows that the changes between 1970 and 1979 involve the growth of the older population in the metropolitan area suburbs ("the aging of the suburbs"), especially in the larger areas. Although the older population in the nonmetropolitan areas also increased, the major patterns remained approximately the same.

The above analysis is based on the total population (see first table after the summary, part A). Patterns for the white elderly and the black elderly are, however, fundamentally different and are analyzed separately in parts B and C. In essence, the analysis shows that blacks of all ages are more concentrated in metropolitan areas than are whites and that better than three-quarters of the older blacks in metropolitan areas live in the central city.

DISTRIBUTION OF POPULATION BY METROPOLITAN/NONMETROPOLITAN RESIDENCE, BY AGE GROUPS, 1970 AND 1979

Residential category	1970		1979		Index[1]		
	Under 65	65-plus	Under 65	65-plus	1970	1979	Ratio[2]
Total	100.0	100.0	100.0	100.0	100	100	100
Metropolitan areas	69.1	64.2	68.1	63.4	93	93	100
In central cities	31.1	34.5	27.8	30.5	111	110	99
Outside central cities	37.9	29.7	40.3	33.0	78	82	105
Metropolitan areas of:							
1,000,000-plus:							
In central cities	16.9	19.8	14.6	16.2	117	111	95
Outside central cities	23.1	18.1	24.0	19.8	78	83	106
Less than 1,000,000:							
In central cities	13.1	14.7	13.2	14.3	112	108	96
Outside central cities	14.8	11.5	16.3	13.2	78	81	104
Nonmetropolitan areas	30.9	35.8	31.9	36.6	116	115	99
In counties with no place of 2,500-plus	3.5	4.7	4.0	5.0	134	125	93
In counties with a place of 2,500 to 24,999	19.5	23.3	20.0	23.3	119	117	98
In counties with a place of 25,000-plus	7.9	7.8	7.9	8.4	99	106	107
In-counties designated metropolitan since 1970	4.2	4.4	4.5	5.0	105	111	106

[1] Index equals proportion of 65-plus divided by proportion under 65 times 100.
[2] Ratio equals index for 1979 divided by index for 1970 times 100.

ANALYSIS OF POPULATION BY METROPOLITAN/NONMETROPOLITAN RESIDENCE, BY AGE GROUPS, 1970 AND 1979

	Number (in thousands)						Percent distribution						Percent change 1970 to 1979		
	Under 45		45-64		65-plus		1970			1979					
Residential category	1970	1979	1970	1979	1970	1979	Under 45	45 to 64	65-plus	Under 45	45 to 64	65-plus	Under 45	45 to 64	65-plus
PART A.—TOTAL															
Total	139,344	149,303	41,240	43,457	19,235	23,175	100.0	100.0	100.0	100.0	100.0	100.0	+7.2	+5.4	+20.5
Metropolitan areas	96,385	101,823	28,329	29,400	12,344	14,698	69.2	68.7	64.2	68.2	67.7	63.4	+5.6	+3.8	+19.1
In central cities	42,829	41,464	13,407	12,044	6,640	7,056	30.7	32.5	34.5	27.8	27.7	30.5	−3.2	−10.2	+6.3
Outside central cities	53,556	60,360	14,922	17,355	5,704	7,642	38.4	36.2	29.7	40.4	39.9	33.0	+12.7	+16.3	+34.0
Metropolitan areas of:															
1,000,000-plus:															
In central cities	22,954	21,712	7,552	6,373	3,818	3,742	16.5	18.3	19.8	14.5	14.7	16.2	−5.4	−15.6	−1.9
Outside central cities	32,393	35,699	9,289	10,601	3,484	4,589	23.2	22.5	18.1	23.9	24.4	19.8	+10.2	+14.1	+31.7
Less than 1,000,000:															
In central cities	17,874	19,753	5,855	5,671	2,825	3,313	12.8	14.2	14.7	13.2	13.1	14.3	+10.5	−3.1	+17.3
Outside central cities	21,163	24,660	5,633	6,754	2,220	3,054	15.2	13.7	11.5	16.5	15.5	13.2	+16.5	+19.9	+37.6
Nonmetropolitan areas	42,959	47,479	12,911	14,057	6,891	8,477	30.8	31.3	35.8	31.8	32.4	36.6	+10.5	+8.9	+23.0
In counties with no place of 2,500-plus	4,738	5,870	1,551	1,796	902	1,149	3.4	3.8	4.7	3.9	4.1	5.0	+23.9	+15.8	+27.4
In counties with a place of 2,500 to 24,999	26,993	29,784	8,253	8,824	4,479	5,393	19.4	20.0	23.3	20.0	20.3	23.3	+10.3	+6.9	+20.4
In counties with a place of 25,000-plus	11,228	11,825	3,108	3,436	1,511	1,936	8.0	7.5	7.8	7.9	7.9	8.4	+5.3	+10.6	+28.1
In counties designated metropolitan since 1970	5,856	6,717	1,664	2,016	843	1,167	4.2	4.0	4.4	4.5	4.6	5.0	+14.7	+21.2	+38.4
PART B.—WHITE															
Total	120,540	126,950	37,204	38,740	17,532	20,950	100.0	100.0	100.0	100.0	100.0	100.0	+5.3	+4.1	+19.5

Metropolitan areas	82,398	84,573	25,333	25,805	11,207	13,168	68.4	68.1	63.9	66.6	66.6	62.9	+2.6	+1.9	+17.5
In central cities	32,089	29,624	11,069	9,415	5,751	5,897	26.6	29.8	32.8	23.3	24.3	23.2	−7.7	−14.9	+2.5
Outside central cities	50,308	54,948	14,264	16,390	5,457	7,272	41.7	38.3	31.1	43.3	42.3	34.7	+9.2	+14.9	+33.3
Metropolitan areas of:															
1,000,000-plus:															
In central cities	15,759	14,006	5,997	4,669	3,251	2,994	13.1	16.1	18.5	11.0	12.1	14.3	−11.2	−22.1	−7.9
Outside central cities	30,461	32,337	8,905	9,970	3,348	4,388	25.3	23.9	19.1	25.5	25.7	21.0	+6.2	+12.0	+31.1
Less than 1,000,000:															
In central cities	16,331	15,619	5,072	4,746	2,500	2,902	13.6	13.6	14.3	12.3	12.3	13.9	−4.4	−6.4	+16.1
Outside central cities	19,848	22,611	5,359	6,420	2,108	2,884	16.5	14.4	12.0	17.8	16.6	13.8	+13.9	+19.8	+36.8
Nonmetropolitan areas	38,143	42,376	11,871	12,935	6,324	7,782	31.6	31.9	36.1	33.4	33.4	37.2	+11.1	+9.0	+23.1
In counties with no place of 2,500-plus	4,039	5,177	1,407	1,646	818	1,038	3.4	3.8	4.7	4.1	4.3	5.0	+28.2	+17.0	+26.9
In counties with a place of 2,500 to 24,999	23,846	26,653	7,565	8,150	4,095	4,987	19.8	20.3	23.4	21.0	21.0	23.8	+11.8	+7.7	+21.8
In counties with a place of 25,000-plus	10,258	10,546	2,898	3,139	1,411	1,757	8.5	7.8	8.1	8.3	8.1	8.4	+2.8	+8.3	+24.5
In counties designated metropolitan since 1970	5,337	6,014	1,559	1,851	789	1,054	4.4	4.2	4.5	4.7	4.8	5.0	+12.7	+18.7	+33.6
PART C.—BLACK															
Total	16,858	19,034	3,649	4,053	1,549	1,954	100.0	100.0	100.0	110.0	100.0	100.0	+12.9	+11.1	+26.1
Metropolitan areas	12,609	14,702	2,706	3,077	1,027	1,325	74.8	74.2	66.3	77.2	75.9	67.8	+16.6	+13.7	+29.0
In central cities	9,939	10,671	2,155	2,380	815	1,029	59.0	59.1	52.6	56.1	58.7	52.7	+7.4	+10.4	+26.3
Outside central cities	2,670	4,032	551	697	212	295	15.8	15.1	13.7	21.2	17.2	15.1	+51.0	+26.5	+39.2
Metropolitan areas of:															
1,000,000-plus:															
In central cities	6,699	6,904	1,446	1,533	519	665	39.7	39.6	33.5	36.3	37.8	34.0	+3.1	+6.0	+28.1
Outside central cities	1,608	2,541	326	463	117	163	9.5	8.9	7.6	13.4	11.4	8.3	+58.0	+42.0	+39.3
Less than 1,000,000:															
In central cities	3,241	3,767	708	847	296	364	19.2	19.4	19.1	19.8	20.9	18.6	+16.2	+19.6	+23.0
Outside central cities	1,062	1,491	226	234	95	133	6.3	6.2	6.1	7.8	5.8	6.8	+40.4	+3.5	+40.0
Nonmetropolitan areas	4,249	4,332	943	976	522	629	25.2	25.8	33.7	22.8	24.1	32.2	+2.0	+3.5	+28.5
In counties with no place of 2,500-plus	578	585	127	126	75	95	3.4	3.5	4.8	3.1	3.1	4.9	+1.2	−0.8	+26.7
In counties with a place of 2,500 to 24,999	2,828	2,672	631	593	357	369	16.8	17.3	23.1	14.0	14.6	18.9	−5.5	−6.0	+3.4
In counties with a place of 25,000-plus	844	1,074	184	257	90	166	5.0	5.0	5.8	5.6	6.3	8.5	+27.3	+39.7	+24.4
In counties designated metropolitan since 1970	496	623	98	156	53	111	2.9	2.7	3.4	3.3	3.9	5.7	+25.6	+50.2	+109.4

VOTER PARTICIPATION

In the 1976 Presidential election, older people made up 15 percent of the voting age population but cast 16 percent of the votes.[13] Some 62 percent of the older population voted, a much higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher *proportion* of older men than older women voted, but the women voters still outnumbered the men. Voter participation falls off sharply after age 75.

In the 1978 congressional election, when, as usual, there is smaller total voter turnout, older people still made up 15 percent of the voting age population but cast 18 percent of the votes. Some 56 percent of the older population voted, a much higher proportion than the under-35 and about the same as the 35–64 group.

The two detailed tables below analyze registration and voting behavior in the 1980 Presidential election by age groups in the population. While the long-term trend toward lower turnouts for voting in both Presidential and congressional elections continued, the relative patterns by age group remained about the same. Highest percentage voting remains with the middle-aged population, followed by the 65–74 group, a falling off in the 75-plus, and a low turnout for the young adults. Whites voted in greater proportions than did the blacks who, in turn, voted in larger proportions than did the Hispanics. Persons aged 65-plus made up 15.4 percent of the voting-age population but cast 16.8 percent of the votes. Older men had better voting records than older women but the larger number of women still meant more female votes (8.7 million versus 7 million). Older whites voted in considerably greater proportions than did blacks or Hispanics. Data for other minorities is not available.

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[13] Computed from data published by the Census Bureau as a result of a supplementary question on the November 1976, 1978, and 1980, Current Population Surveys.

REPORTED REGISTRATION AND VOTING, BY AGE GROUP, NOVEMBER 1980

[Civilian, noninstitutional population; numbers in thousands]

Status	18-plus		18-44		45-64		65-plus					
							Total		65-74		75-plus	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Perc
All races:												
Both sexes	157,085	100.0	89,423	100.0	43,570	[illegible]	24,094	100.0	15,324	100.0	8,770	100
Registered	105,035	66.9	54,039	60.4	33,029	75.8	17,968	74.6	11,835	77.2	6,133	69
Voted	93,066	59.2	47,183	52.8	30,205	69.3	15,677	65.1	10,622	69.3	5,055	57
Did not vote	11,969	7.6	6,856	7.7	2,824	6.5	2,290	9.5	1,213	7.9	1,077	12
Not registered [1]	52,050	33.1	35,384	39.6	10,541	24.2	6,125	25.4	3,488	22.8	2,637	30
Not U.S. citizen	6,343	4.0	4,420	4.9	1,345	3.1	580	2.4	340	2.2	240	2
Male	74,082	100.0	43,326	100.0	20,837	100.0	9,920	100.0	6,676	100.0	3,244	100
Registered	49,344	66.6	25,620	59.1	15,903	76.3	7,821	78.8	5,343	80.0	2,478	76
Voted	43,753	59.1	22,215	51.3	14,554	69.8	6,984	70.4	4,852	72.7	2,132	65
Did not vote	5,591	7.5	3,406	7.9	1,348	6.5	836	8.4	490	7.3	346	10
Not registered [1]	24,738	33.4	17,705	40.9	4,934	23.7	2,098	21.1	1,333	20.0	765	23
Not U.S. citizen	2,942	4.0	2,164	5.0	592	2.8	186	1.9	110	1.6	76	2
Female	83,003	100.0	46,097	100.0	22,732	100.0	14,174	100.0	8,648	100.0	5,526	100.
Registered	55,691	67.1	28,418	61.6	17,126	75.3	10,147	71.6	6,493	75.1	3,654	66.
Voted	49,312	59.4	24,967	54.2	15,651	68.9	8,694	61.3	5,770	66.7	2,924	52.
Did not vote	6,378	7.7	3,449	7.5	1,475	6.5	1,454	10.3	723	8.4	731	13.
Not registered [1]	27,312	32.9	17,678	38.3	5,606	24.7	4,027	28.4	2,155	24.9	1,872	33.
Not U.S. citizen	3,402	4.1	2,255	4.9	752	3.3	394	2.8	230	2.7	164	3.
White:												
Both sexes	137,676	100.0	77,225	100.0	38,703	100.0	21,748	100.0	13,789	100.0	7,959	100.
Registered	94,112	68.4	47,898	62.0	29,808	77.0	16,406	75.4	10,755	78.0	5,651	71.
Voted	83,855	60.9	42,143	54.6	27,365	70.7	14,347	66.0	9,669	70.1	4,678	58.
Did not vote	10,257	7.5	5,756	7.5	2,443	6.3	2,058	9.5	1,085	7.9	973	12.
Not registered [1]	43,564	31.6	29,327	38.0	8,895	23.0	5,343	24.6	3,034	22.0	2,309	29.
Not U.S. citizen	4,762	3.5	3,260	4.2	1,038	2.7	463	2.1	263	1.9	200	2.
Black:												
Both sexes	16,423	100.0	10,224	100.0	4,159	100.0	2,039	100.0	1,352	100.0	687	100.
Registered	9,849	60.0	5,537	54.2	2,885	69.4	1,429	70.1	998	73.8	431	70.
Voted	8,287	50.5	4,530	44.3	2,546	61.2	1,211	59.4	877	64.9	334	48.
Did not vote	1,562	9.5	1,005	9.8	339	8.2	218	10.7	121	8.9	97	14.
Not registered [1]	6,574	40.0	4,668	45.9	1,275	30.7	610	29.9	354	30.7	256	37.
Not U.S. citizen	472	2.9	354	3.5	101	2.4	18	.9	12	.9	6	.
Spanish origin: [2]												
Both sexes	8,210	100.0	5,874	100.0	1,798	100.0	538	100.0	349	100.0	189	100.
Registered	2,984	36.3	1,837	31.3	910	50.6	237	44.1	160	45.8	77	40.
Voted	2,453	29.9	1,488	25.3	768	42.7	198	36.8	141	40.4	57	30.
Did not vote	531	6.5	348	5.9	143	8.0	40	7.4	20	5.7	20	10.
Not registered [1]	5,226	63.7	4,037	68.7	888	49.4	301	55.9	189	54.2	112	59.
Not U.S. citizen	2,645	32.2	1,987	33.8	489	27.2	168	31.2	115	33.0	53	28.

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[1] Spanish origin may be of any race.

[2] Includes "not known" and "unreported."

COMPARISON OF DISTRIBUTION OF POPULATION AND OF VOTERS, BY AGE GROUP, NOVEMBER 1980

[Civilian, noninstitutional population]

Status	18-plus		18-44		45-64		65-plus: Total		65-plus: 65-74		65-plus: 75-plus	
	Persons	Voters	Persons	Voters	Persons	Voters	Persons	Voters	Persons	Voters	Persons	Voters
All races, both sexes	100.0	100.0	56.9	50.7	27.7	32.5	15.4	16.8	9.8	11.4	5.6	5.4
Male	100.0	100.0	58.5	50.6	28.1	33.3	13.4	16.0	9.0	11.1	4.4	4.9
Female	100.0	100 0	55.5	50.6	27.4	31.7	17.1	17.7	10.4	11.7	6.7	6.0
White	100.0	100.0	56.1	50.3	28.1	32.6	15.8	17.1	10.0	11.5	5.8	5.6
Black	100.0	100.0	62.3	54.7	25.3	30.7	12.4	14.6	8.2	10.6	4.2	4.0
Spanish origin [1]	100.0	100.0	71.5	60.7	21.9	31.3	6.6	8.0	4.3	5.7	2.3	2.3
All races, both sexes	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Male	47.2	47.0	48.5	47.1	47.8	48.2	41.2	44.5	43.6	45.7	37.0	42.2
Female	52.8	52.0	51.5	52.9	52.2	51.8	58.8	55.5	56.4	54.3	63.0	57.8
White	87.6	90.1	86.4	89.3	88.8	90.6	90.3	91.5	90.0	91.0	90.8	92.5
Black	10.5	8.9	11.4	9.6	9.5	8.4	8.5	7.7	8.8	8.3	7.8	6.6
Spanish origin [1]	5.2	2.6	6.6	3.2	4.1	2.5	2.2	1.3	2.3	1.3	2.2	1.1

[1] Spanish origin may be of any race.

MOBILITY

There are two ways of examining the mobility of older persons. One, called "general mobility" by the Census Bureau, is based on a more geographic approach and measures movers (people who change residences) as to whether they moved across county, State, and regional lines. The other, called "detailed mobility" by the Census Bureau, is based on a type of residential area approach and measures movers in relation to residence in a central city or suburb of a metropolitan area or of a nonmetropolitan area.

General Mobility

In the March 1979 household survey, only 3.9 million or 17 percent of the 65-plus noninstitutionalized population reported that they had moved in the 4-year period since 1975 (compared with over 43 percent for the population aged 4 and over). Of the 3.9 million older movers in the 1975–79 period, 57 percent moved within the same county, 22 percent moved to another county in the same State, 6 percent moved to a contiguous State, and 15 percent moved to a noncontiguous State. Although differing in proportions, older movers followed a pattern quite similar to that of movers of all ages as shown in the table below.

GENERAL MOBILITY, BY AGE GROUPINGS, 1975/1979 [1]

[Numbers in thousands]

Region and residence in 1979 compared to region and residence in 1975	Age 4 to 64: Number	Age 4 to 64: Percent	Age 4 to 64: Percent	Age 65-plus: Number	Age 65-plus: Percent	Age 65-plus: Percent
Total in 1979	180,262	100.0	....	23,175	100.0	....
Same house (nonmovers)	99,437	55.2	....	19,161	82.7	....
Different house within United States (movers)	77,895	43.2	100.0	3,923	17.0	100.0
Same county	44,945	24.9	57.7	2,223	9.6	56.6
Different county	32,949	18.3	42.3	1,707	7.4	43.5
Same State	17,341	9.6	22.3	879	3.8	22.4
Different State	15,607	8.7	20.0	828	3.6	21.1
Contiguous	4,852	2.7	6.2	247	1.1	6.3
Noncontiguous	10,756	6.0	13.8	580	2.5	14.8
Northeast in 1975	3,044	1.7	3.9	214	.9	5.5
North Central in 1975	3,942	2.2	5.1	224	1.0	5.7
South in 1975	5,198	2.9	6.7	270	1.2	6.9
West in 1975	3,424	1.9	4.4	120	.5	3.1
Movers from abroad	2,931	1.6	....	85	.1	....

See footnote at end of table.

XLIII

GENERAL MOBILITY, BY AGE GROUPINGS, 1975/1979—Continued

[Numbers in thousands]

Region and residence in 1979 compared to region and residence in 1975	Age 4 to 64			Age 65-plus		
	Number	Percent	Percent	Number	Percent	Percent
Northeast in 1979	40,638	100.0	....	5,598	100.0	....
Same house (nonmovers)	26,285	64.7	....	4,865	86.9	....
Different house within United States (movers)	13,795	34.0	100.0	720	12.9	100.0
Same county	8,780	21.6	63.7	452	8.1	62.8
Different county	5,015	12.3	36.4	268	4.8	37.2
Same State	2,962	7.3	21.5	166	3.0	23.1
Different State	2,053	5.0	14.9	102	1.8	14.2
Northeast in 1975	1,057	2.6	7.7	63	1.1	8.8
North Central in 1975	238	.6	1.7	6	.1	.8
South in 1975	593	1.5	4.3	28	.5	3.9
West in 1975	166	.4	1.2	5	.1	.7
Movers from abroad	559	1.4	....	13	.2	....
North Central in 1979	47,780	100.0	....	6,141	100.0	....
Same house (nonmovers)	27,128	56.8	....	5,181	84.4	....
Different house within United States (movers)	20,181	42.2	100.0	956	15.6	100.0
Same county	12,234	25.6	60.6	609	9.9	63.7
Different county	7,947	16.6	39.4	347	5.7	36.3
Same State	4,798	10.0	23.8	237	3.9	24.8
Different State	3,151	6.6	15.6	109	1.8	11.4
Northeast in 1975	297	.6	1.5	7	.1	.7
North Central in 1975	1,387	2.9	6.9	42	.7	4.4
South in 1975	939	2.0	4.7	52	.9	5.4
West in 1975	527	1.1	2.6	8	.1	.8
Movers from abroad	471	1.0	....	4	.1	....
South in 1979	58,334	100.0	....	7,560	100.0	....
Same house (nonmovers)	31,086	53.3	....	6,251	82.7	....
Different house within United States (movers)	26,315	45.1	100.0	1,295	17.1	100.0
Same county	14,258	24.4	54.2	625	8.3	48.3
Different county	12,057	20.7	45.8	670	8.9	51.7
Same State	5,922	10.2	22.5	264	3.5	20.4
Different State	6,136	10.5	23.3	405	5.4	31.3
Northeast in 1975	1,090	1.9	4.1	132	1.8	10.2
North Central in 1975	1,359	2.3	5.2	95	1.3	7.3
South in 1975	2,804	4.8	10.7	151	2.0	11.7
West in 1975	882	1.5	3.4	27	.4	2.1
Movers from abroad	933	1.6	....	14	.2	....
West in 1979	33,509	100.0	....	3,877	100.0	....
Same house (nonmovers)	14,938	44.6	....	2,864	73.9	....
Different house within United States (movers)	17,603	52.5	100.0	959	24.7	100.0
Same county	9,674	28.9	55.0	536	13.8	55.9
Different county	7,929	23.7	45.0	423	10.9	44.1
Same State	3,661	10.9	20.8	211	5.4	22.0
Different State	4,268	12.7	24.2	212	5.5	22.1
Northeast in 1975	599	1.8	3.4	13	.3	1.4
North Central in 1975	959	2.9	5.5	80	2.1	8.3
South in 1975	862	2.6	4.9	39	1.0	4.1
West in 1975	1,850	5.5	10.5	79	2.0	8.2
Movers from abroad	967	2.9	....	54	1.4	....

[1] Computed from data published by the Census Bureau, reporting replies in the March 1980 Current Population Survey comparing location of residence in 1979 and in 1975.

A special analysis of the regional pattern of interstate movers over the 4-year period 1975–79 (see table below) shows some degree of concentration of movement but very far from the stereotypic belief of a large flow to the "sunbelt." First of all, only 828,000 or 3.6 percent of the older noninstitutionalized population in 1979 reported an interstate move in the previous 4 years; this represents 21.1 percent of the movers.

Starting with residence in 1975, of the 215,000 who lived in the Northeast, about 30 percent moved to another State in the Northeast and over 60 percent moved to a State in the South. Of the 223,000 movers who lived in the North Central States in 1975, about 19 percent moved to another State in the same region, 43 percent moved to the South and 36 percent to the West. Of the 270,000 movers who lived in the South in 1975, 56 percent moved within the South, about 30 percent moved northwards, and some 14 percent moved West. Of the 119,000 who lived in a Western State in 1975, more than 66 percent moved within the West and 23 percent to a State in the South.

XLIV

REGIONAL PATTERNS OF INTERSTATE MOVERS AGED 65-PLUS, 1975/1979

Residence in 1979	Residence in 1975				
	Total	Northeast	North Central	South	West
Total number (thousands)	828	215	223	270	119
Northeast	102	63	6	28	5
North Central	109	7	42	52	8
South	405	132	95	151	27
West	212	13	80	39	79
Total percent (1975)	100.0	100.0	100.0	100.0	100.0
Northeast	12.3	29.3	2.7	10.4	4.2
North Central	13.2	3.3	18.8	19.3	6.7
South	48.9	61.4	42.6	55.9	22.7
West	25.6	6.0	35.9	14.4	66.4
Total percent (1979)	100.0	26.0	26.9	32.6	14.4
Northeast	100.0	61.8	5.9	27.4	4.9
North Central	100.0	6.4	38.5	47.7	7.3
South	100.0	32.6	23.5	37.3	6.7
West	100.0	6.1	37.7	18.4	37.3

Detailed Mobility

In 1979, 19.2 million or about 83 percent of the noninstitutionalized older people reported that they lived in the same house as they did in 1975. A quarter were living within the central city of a metropolitan area, 27 percent were still living in a suburb, and about 31 percent were still in a nonmetropolitan area.

Of the 3.9 million movers (17 percent of the older population), 44 percent reported a move within the same metropolitan area—21.3 percent moved within the central city, 14.4 percent within the suburbs, and 8.3 percent moved between the central city and the suburbs (both directions).

Almost 16 percent of the movers moved from one metropolitan area to another, about a third moving from a suburb in one area to a suburb in the new area.

More than a quarter of the movers moved from one nonmetropolitan area to another nonmetropolitan area with the remaining 15 percent of the movers moving in a criss-cross pattern. (See table below.)

XLV

DETAILED MOBILITY, BY AGE GROUPINGS, 1975/1979

[Numbers in thousands]

Residence in 1979 compared to residence in 1975	Age 4 to 64			Age 65-plus		
	Number	Percent	Percent	Number	Percent	Percent
Total	180,262	100.0	(1)	23,175	100.0	(1)
Same house (nonmovers)	99,437	55.2	(1)	19,161	82.7	(1)
Central city of SMSA	25,997	14.4	(1)	5,792	25.0	(1)
Balance of SMSA	41,336	22.9	(1)	6,260	27.0	(1)
Outside SMSA	32,101	17.8	(1)	7,111	30.7	(1)
Different house within United States (movers)	77,895	43.2	100.0	3,929	17.0	100.0
Within same SMSA	36,067	20.0	46.3	1,724	7.4	43.9
Within central city	13,824	7.7	17.7	835	3.6	21.3
Within balance of SMSA	14,735	8.2	18.9	567	2.4	14.4
Central city to balance of SMSA	5,369	3.0	6.9	238	1.0	6.1
Balance of SMSA to central city	2,138	1.2	2.7	85	.4	2.2
Between SMSA's	12,180	6.8	15.6	623	2.7	15.9
Between central cities	2,832	1.6	3.6	132	.6	3.4
Between balances of SMSA's	4,384	2.4	5.6	219	.9	5.5
Central city to balance of SMSA	3,115	1.7	4.0	183	.8	4.7
Balance of SMSA to central city	1,850	1.0	2.4	89	.4	2.3
From outside SMSA to an SMSA	4,949	2.7	6.4	222	1.0	5.7
To central city	1,961	1.1	2.5	77	.3	2.0
To balance of SMSA	2,968	1.7	3.8	145	.6	3.7
From SMSA to outside SMSA	6,320	3.5	8.1	371	1.6	9.4
From central city	2,880	1.6	3.7	214	.9	5.4
From balance of SMSA	3,441	1.9	4.4	156	.7	4.0
Outside SMSA at both dates	18,377	10.2	23.6	990	4.3	25.2
Movers from abroad	2,931	1.6	(1)	85	.4	(1)
To central city of SMSA	1,311	.7	(1)	46	.2	(1)
To balance of SMSA	1,126	.6	(1)	30	.1	(1)
To outside SMSA	496	.3	(1)	7	(2)	(1)

[1] Not applicable.
[2] Less than 0.05 percent.

VETERANS

PROJECTED NUMBER OF ALL MALES AND OF VETERANS, AGED 65 AND OVER, 1980, 1990, 2000[1]

[Numbers in thousands]

Age	1980			1990			2000		
		Veterans			Veterans			Veterans	
	Males	Number	Percent	Males	Number	Percent	Males	Number	Percent
65-plus	10,100	2,960	29.3	12,000	7,188	59.9	12,716	7,821	61.5
65 to 69	3,859	1,510	39.1	4,471	3,586	80.2	4,152	2,181	52.5
70 to 74	2,853	710	24.9	3,281	2,295	70.0	3,521	2,251	63.9
75 to 79	1,698	186	11.0	2,148	873	40.6	2,509	2,059	82.1
80 to 84	990	299	30.2	1,264	316	25.0	1,472	1,027	69.8
85-plus	709	255	36.0	836	118	14.1	1,062	303	28.5

[1] Based on data supplied by the Veterans Administration and the Health Care Financing Administration, and a special site visit survey of VA geriatric research, education, and clinical centers.

As may be seen from the above table, veterans are an increasingly large proportion of the older male population, reaching 60 percent within the next 10 years. Aware of this rapidly increasing responsibility, the Veterans Administration has initiated a large number of programs in domiciliary, home, and institutional care areas, as well as extensive research in both the biomedical and social/behavioral aspects of aging. Beginning in 1973, the Veterans Administration has established 10 geriatric research, education, and clinical centers (GRECC) scattered across the country from Massachusetts to California, providing both direct programs and support to the other VA programs and facilities.

In 1978, the Veterans Administration spent $1,053 billion in health care of the older veterans.

EMPLOYMENT

In 1900, the male labor force numbered 27,640,000. In the 45-64 age group, there were 4,958,000 men in the labor force out of a total male population in this age group of 5,465,000 or a labor force participation rate of 90.3. The 65-plus male population totaled 1,555,000 so the 987,000 in the labor force represented a rate of 63.1. In the female labor force of 4,999,000, there were 672,000 aged 45–64 in the labor force or 13.6 percent of the 4,935,000 women aged 45–64 in the population. In the 65-plus group, there were 127,000 in the labor force out of a population of 1,525,000 older women or a rate of 8.3.

Between 1900 and 1950, the male 45–64 labor force participation rate remained relatively constant while the 65-plus rate fell rapidly, especially after the onset of the depression of the 1930's and the passage of the Social Security Act. The 45–64 rate for women showed a steady increase as women entered the labor market but the 65-plus rate moved slowly between 8 and 10 percent.

The following table analyzes the trends since 1950 in some detail. The long-term trends for women continue as previously but for men the decrease in labor force participation has moved down to just below 60 years of age. This "early retirement" phenomena (which also showed up in the increase in the number of persons claiming social security payments prior to age 65, even at reduced benefit amounts) is probably a combination of persons under 65 voluntarily opting for early retirement (especially if they have other retirement income), of persons unable to find jobs in their later years (the so-called discouraged worker) and of persons who for health or physical reasons cannot continue to work.

CIVILIAN LABOR FORCE PARTICIPATION RATES, PERSONS AGED 45 AND OVER, BY AGE GROUP AND SEX, 1950–79 [1]

Sex and age group	1950	1955	1960	1965	1970	1975	1979
Men:							
10 yr:							
45 to 54	95.8	96.5	95.7	95.6	94.2	92.1	91.4
55 to 64	86.9	87.9	86.8	84.6	83.0	75.8	73.0
65-plus	45.8	39.6	33.1	27.9	26.8	21.7	20.0
5 yr:							
45 to 49	NA	97.1	96.6	96.1	95.3	94.1	93.4
50 to 54	NA	95.7	94.7	95.0	93.1	90.1	89.6
55 to 59	NA	92.5	91.6	90.2	89.5	84.4	82.2
60 to 64	NA	82.5	81.1	78.0	75.0	65.7	61.8
65-plus	45.8	39.6	33.1	27.9	26.8	21.7	20.0
Women:							
10 yr:							
45 to 54	37.9	43.8	49.8	50.9	54.4	54.6	58.4
55 to 64	27.0	32.5	37.2	41.4	43.0	41.0	41.9
65-plus	9.7	10.6	10.8	10.0	9.7	8.3	8.3
5 yr:							
45 to 49	NA	45.9	50.7	51.7	55.0	55.9	60.4
50 to 54	NA	41.5	48.7	50.1	53.8	53.3	56.5
55 to 59	NA	35.6	42.2	47.1	50.4	47.9	48.7
60 to 64	NA	29.0	31.4	34.0	36.1	33.3	33.9
65-plus	9.7	10.6	10.8	10.0	9.7	8.3	8.3

[1] From published and unpublished data supplied by the Department of Labor.

The following table presents a more detailed analysis of the labor force and the status of its components in the third quarter of 1980 by sex and 5-year age groupings. Noteworthy are the sharp decreases in labor force participation rates with increasing age, the increase in the proportion of employed workers in agriculture with advancing age, especially for men, and the decrease in unemployment rate (though not the duration of unemployment).

LABOR FORCE STATUS OF THE CIVILIAN NONINSTITUTIONAL POPULATION BY AGE GROUP AND SEX, JULY-SEPTEMBER 1980

[Numbers in thousands]

Status	16-plus	55-59	60-64	65-69	70-74	75-plus
Both sexes: Total	164,475	11,286	9,730	8,593	6,667	8,693
In labor force	105,948	7,220	4,512	1,800	774	426
Participation rate	64.4	64.0	46.4	20.9	11.6	4.9
Employed	97,986	6,970	4,384	1,736	750	419
Agriculture	3,708	283	268	158	99	70
Percent of employed	3.8	4.1	6.1	9.1	13.2	16.7
Nonagriculture	94,278	6,688	4,117	1,577	651	349
Unemployed	7,961	250	128	66	24	7
Rate	7.5	3.5	2.8	3.7	3.1	1.6
Not in labor force	58,527	4,065	5,218	6,793	5,893	8,267
Percent of total	35.6	36.0	53.6	79.1	88.4	95.1
Male: Total	77,853	5,373	4,550	3,824	2,821	3,217
In labor force	61,115	4,393	2,792	1,078	506	293
Participation rate	78.5	81.8	61.4	28.2	17.9	9.1
Employed	56,730	4,237	2,708	1,038	492	286
Agriculture	2,929	223	232	142	86	62
Percent of employed	5.2	5.3	8.6	13.7	17.5	21.7
Nonagriculture	53,801	4,014	2,475	896	405	224
Unemployed	4,385	156	84	40	14	7
Rate	7.2	3.6	3.0	3.7	2.8	2.5
Not in labor force	16,738	980	1,758	2,745	2,315	2,924
Percent of total	21.5	18.2	38.6	71.8	82.1	90.9
Female: Total	86,622	5,913	5,180	4,769	3,846	5,476
In labor force	44,832	2,827	1,720	722	268	133
Participation rate	51.8	47.8	33.2	15.1	7.0	2.4
Employed	41,256	2,733	1,677	698	258	133
Agriculture	770	59	35	16	13	8
Percent of employed	1.9	2.2	2.1	2.3	5.0	6.0
Nonagriculture	40,477	2,674	1,642	681	246	125
Unemployed	3,576	94	43	26	10	0
Rate	8.0	3.3	2.5	3.6	3.7	0
Not in labor force	41,790	3,085	3,460	4,048	3,578	5,343
Percent of total	48.2	52.2	66.8	84.9	93.0	97.9

The following table analyzes the employment and unemployment status in the third quarter of 1980 for older members of the labor force according to their full-time or part-time attachment to the labor force. Especially noteworthy is the very rapid increase in the proportion of part-time workers, both men and women, with advancing age.

XLVIII

FULL-TIME/PART-TIME STATUS OF THE CIVILIAN NONINSTITUTIONAL POPULATION BY AGE GROUP AND SEX, JULY–SEPTEMBER 1980

[Numbers in thousands]

Status	16-plus	55–59	60–64	65-plus
Both sexes:				
Full-time labor force	92,083	6,523	3,827	1,547
Employed	85,401	6,300	3,721	1,491
Full time	80,603	6,065	3,576	1,366
Part time (economic reasons)	4,798	235	145	125
Unemployed	6,682	222	105	56
Rate	7.3	3.4	2.7	3.6
Part-time labor force	13,865	698	685	1,453
Percent of total labor force	13.1	9.7	15.2	48.4
Employed part time	12,586	670	663	1,414
Percent of total employed	12.8	9.6	15.1	48.7
Unemployed	1,279	28	23	39
Rate	9.2	3.9	3.3	2.7
Percent of total unemployed	16.1	11.0	17.7	40.9
Male:				
Full-time labor force	56,891	4,248	2,537	1,062
Employed	53,014	4,098	2,466	1,024
Full time	50,620	3,989	2,393	954
Part time (economic reasons)	2,394	109	73	70
Unemployed	3,877	149	71	39
Rate	6.8	3.5	2.8	3.7
Part-time labor force	4,224	146	255	815
Percent of total labor force	6.9	3.3	9.1	43.4
Employed part time	3,716	138	241	794
Percent of total employed	6.6	3.3	8.9	43.7
Unemployed	508	7	13	22
Rate	12.0	5.0	5.2	2.7
Percent of total unemployed	11.6	4.7	15.7	36.1
Female:				
Full-time labor force	35,192	2,275	1,289	485
Employed	32,386	2,202	1,255	468
Full time	29,983	2,076	1,183	412
Part time (economic reasons)	2,403	126	72	56
Unemployed	2,805	74	34	17
Rate	8.0	3.2	2.6	3.6
Part-time labor force	9,640	552	431	637
Percent of total labor force	21.5	19.5	25.0	56.8
Employed part time	8,869	532	421	620
Percent of total employed	21.5	19.5	25.1	57.0
Unemployed	771	20	9	17
Rate	8.0	3.7	2.2	2.7
Percent of total unemployed	21.6	21.5	21.4	49.5

AUTOMOBILE OWNERSHIP

As is true for major household appliances, automobile ownership by older households is well below that of households with younger heads but part of the difference depends on income level rather than age, health, or choice. A 1974 survey showed that 62 percent of older households owned at least one car as compared with 86 percent for the younger.[14] There is, however, a strong relationship between income level and auto ownership at all ages so the lower income level of the older households accounts in part for the lower ownership rate. Other factors are also present.

PROJECTIONS

The "safest" Census Bureau projections of the size and composition of the population through 2050 are the so-called "Series II" projections, which are based on an ultimate cohort fertility rate of 2.1 (2.1 children per woman or eventual zero population growth), small improvements in life expectancy (including that for older persons), narrowing of the gap between whites and blacks, constant 400,000 net immigration, but no new major medical "cures" of chronic diseases.

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[14] Basic data from the discontinued Census Bureau series on Consumer Buying Intentions.

These projections show a total population of 260.4 million by 2000 with 31.8 million or 12.2 percent aged 65-plus (11.2 percent in 1979). The number of 85-plus persons would almost double to 3.8 million and the ratio of 65-plus women to men would rise to 150 to 100 as compared with 146 to 100 in 1979.

POPULATION PROJECTIONS (SERIES II), TOTAL AND 65-PLUS, 1980-2050[1]

[Numbers in thousands]

Year	All ages	65-plus				
		Both sexes			Female	
		Number	Percent of all ages	Male	Number	Per 100 men
1980	222,159	24,927	11.2	10,108	14,819	147
1985	232,880	27,305	11.7	11,012	16,293	148
1990	243,513	29,824	12.3	11,999	17,824	149
1995	252,750	31,401	12.4	12,602	18,799	149
2000	260,378	31,822	12.2	12,717	19,105	150
2005	267,603	32,436	12.1	12,924	19,512	151
2010	275,335	34,837	12.7	13,978	20,858	149
2015	283,164	39,519	14.0	16,063	23,456	146
2020	250,115	45,102	15.6	18,468	26,634	144
2025	295,742	50,920	17.2	20,861	30,059	144
2030	300,349	55,024	18.3	22,399	32,624	146
2035	304,486	55,805	18.3	22,434	33,371	149
2040	308,400	54,925	17.8	21,816	33,108	152
2045	312,054	54,009	17.3	21,335	32,674	153
2050	315,622	55,494	17.6	22,055	33,439	152

[1] Computed from the latest Census Bureau population projections (by age, sex, and color) as published in the Current Population Reports series. Detailed tables are based on the series II projections which assumed a 2.1 or "zero population growth," fertility rate for the future. Dependency ratios (gross) computed by the author from the projections and from data from previous census enumerations.

If the present fertility rate of approximately 1.8 (children per woman) should continue at this low level rather than the 2.1 rate assumed above, the size of the total population would be smaller but the *proportion* of older people would be larger. The increasing number and proportion of older persons reflect both the impact of longer life expectancy and the movement of the post-World War II baby boom through the population pyramid. Projections based on lower fertility rates also show a much smaller rate of growth for the older population after 2030 when today's babies and youngsters start reaching age 65.

The above projections represent averages for the whole 65-plus age group as if it were a homogeneous mass. Important differences by sex and age group within the 65-plus population are as follows:

PROJECTED TRENDS WITHIN THE 65-PLUS AGE GROUP, 1976-2050

[Percent change]

Sex and age	1976-2000	2000-25	2025-50
Both sexes, 65-plus	+38.8	+60.0	+9.0
65 to 74	+22.8	+77.5	−6.7
75 to 84	+56.9	+41.1	+14.9
85-plus	+91.1	+32.4	+91.6
Male 65-plus	+35.8	+64.0	+5.7
65 to 74	+24.4	+79.1	−6.3
75 to 84	+55.0	+44.1	+13.5
85-plus	+68.8	+29.9	+92.9
Female 65-plus	+40.8	+57.3	+11.2
65 to 74	+21.6	+76.2	−7.1
75 to 84	+58.0	+39.4	+14.3
85-plus	+101.4	+33.4	+91.1

Thus, comparison of the approximately 25-year timespans shows continuing increase to 2000, very rapid growth from 2000 to 2025 as the postwar babies reach the later years, then a sharp deceleration as the current low birth rates are reflected in a smaller cohort reaching 65. Significantly, the usually more rapid growth in the number of older women is reversed in the 2000 to 2025 period. But of even greater significance is the fact that between now and 2000 the oldest part of the older population will grow most rapidly, then be reversed between 2000 and 2025 and return to the current trend after 2025 when all rates of growth will be much slower, especially in the "younger" aged.

Does the age shift in the population create insurmountable "burdens"? Computation of a gross dependency ratio based on the assumption that the young (under 18) and the old (65-plus) are dependent on the middle group, the so-called "productive age" population, tends to show a quite reasonable "burden" on the middle group under reasonable economic and labor force assumptions:

Year	Number aged under 18 per 100 aged 18–64	Number aged 65-plus per 100 aged 18–64	Total
1930	58.9	9.1	68.0
1940	48.9	11.0	59.9
1950	51.0	13.4	64.4
1960	65.1	16.8	81.9
1970	61.4	17.7	79.1
1980[1]	45.8	18.4	64.2
1990[1]	43.5	20.0	63.5
2000[1]	43.2	19.9	63.1
2010[1]	39.2	20.2	59.4
2020[1]	41.2	26.0	67.2
2030[1]	42.0	31.8	73.8
2040[1]	41.2	30.6	71.8
2050[1]	41.7	30.2	71.9

[1] Projections, series II.

Exhibit A

RECENT STATE TRENDS IN THE OLDER POPULATION, 1970–79[15]

Between 1970 and 1979, the Nation's older population (65-plus) increased from 20 million to 24.7 million or from 9.8 percent to 11.2 percent of the total population. As has been true for most of the 20th century, the older population grew considerably faster in 1970–79 (23.5 percent) than did the under-65 population (6.3 percent). These national trends, however, represent the averaging out of a variety of different State trends. Details and analyses are presented below.

PROPORTION OF THE POPULATION AGED 65-PLUS

For the Nation as a whole (50 States and the District of Columbia), the proportion of the total population in the 65-plus group rose from 9.8 percent in 1970 to 11.2 percent in 1979. The proportion ranged from 2.6 percent in Alaska and 7.7 percent in Hawaii to 18.1 percent in Florida and 13.7 percent in Arkansas.

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[15] Computed by the author from reports on the 1970 census enumeration and from Census Bureau estimates of the population by age and by State for 1979, published in the Current Population Reports series.

In Wyoming, the only State where the under-65 group grew faster than the 65-plus, the proportion of older persons actually dropped, from 9.1 percent in 1970 to 8.1 percent in 1979. In five States (Alaska, Colorado, Idaho, New Hampshire, and Utah), the increase in the proportion of the State's aged population was 0.5 percentage points or less in the 9-year period. The remaining States had larger gains.

SUMMARY: STATES BY PERCENT OF POPULATION AGED 65-PLUS, 1979

18.1	1	Florida.
13.3 to 14.2	1	Arkansas.
12.3 to 13.2	10	Iowa, Kansas, Maine, Massachusetts, Missouri, Nebraska, Oklahoma, Pennsylvania, Rhode Island, and South Dakota.
11.3 to 12.2	11	Arizona, Connecticut, Minnesota, Mississippi, New Jersey, New York, North Dakota, Oregon, Vermont, West Virginia, and Wisconsin.
11.2[1]	3	Alabama, Kentucky, and Tennessee.
10.2 to 11.1	9	California, District of Columbia, Illinois, Indiana, Montana, New Hampshire, North Carolina, Ohio, and Washington.
9.2 to 10.1	9	Delaware, Georgia, Idaho, Louisiana, Maryland, Michigan, South Carolina Texas, and Virginia.
8.2 to 9.1	3	Colorado, Nevada, and New Mexico.
7.2 to 8.1	3	Hawaii, Utah, and Wyoming.
2.6	1	Alaska.
Total	51	

[1] National average.

DISTRIBUTION AMONG THE STATES

The older population tends to be distributed among the States in the same general pattern as the total population except that there is a slightly greater concentration of older persons in some of the larger States. In the analytical table by State rank order (see last table of this exhibit), at the points where the States in the total population column and the 65-plus population column match exactly, the percentages are as follows:

States	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	10.3	10.3	9.4	9.4
New York	8.0	18.3	8.6	18.0
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.6	47.9	31.1	49.1
New Jersey	3.3	51.2	3.4	52.5
Massachusetts	2.6	53.8	2.9	55.4
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee	16.1	69.9	15.5	70.9
Maryland, Minnesota, Louisiana, Washington, Alabama, Kentucky, Connecticut, South Carolina, Iowa, Oklahoma, Colorado, Oregon, Arizona, Mississippi, Kansas, Arkansas	22.7	92.6	22.3	93.2
West Virginia	.9	93.5	.9	94.1
Nebraska	.7	94.2	.8	94.9
Utah, New Mexico, Maine, Rhode Island	2.1	96.3	1.9	96.8
Hawaii, Idaho, New Hampshire, Montana, Nevada, South Dakota, North Dakota, District of Columbia	2.8	99.1	2.7	99.5
Delaware	.3	99.4	.2	99.7
Vermont	.2	99.6	.2	99.9
Wyoming	.2	99.8	.1	100.0
Alaska	.2	100.0	------------	100.0

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1979

State	Number (in thousands)		Percent increase		Percent of all ages		State rank [2]					
							Number		Percent increase		Percent of all ages	
	1970 [1]	1979	1960-70	1970-79	1970	1979	1970	1979	1960-70	1970-79	1970	1979
Total, 51 States	19,972	24,658	21.1	23.5	9.8	11.2	(³)	(³)	(³)	(³)	(³)	(³)
Alabama	324	421	24.7	29.7	9.4	11.2	21	19	16	16	30	25
Alaska	7	10	27.9	54.2	2.3	2.6	51	51	11	6	51	51
Arizona	161	289	79.0	79.5	9.1	11.8	35	30	1	2	34	16
Arkansas	237	300	22.0	26.6	12.3	13.7	28	28	21	22	3	2
California	1,792	2,316	30.9	29.3	9.0	10.2	2	1	9	18	36	34
Colorado	187	239	18.8	27.8	8.5	8.6	33	33	24	20	38	47
Connecticut	288	356	19.1	24.0	9.5	11.4	26	26	23	26	27	21
Delaware	44	57	22.6	30.0	8.0	9.7	48	48	20	15	42	37
District of Columbia	70	73	2.4	3.2	9.3	11.1	41	45	51	51	32	28
Florida	985	1,603	78.2	62.7	14.5	18.1	7	3	2	3	1	1
Georgia	365	488	26.4	33.6	8.0	9.5	17	16	15	11	42	40
Hawaii	44	70	51.3	59.9	5.7	7.7	47	46	4	4	50	50
Idaho	67	91	16.3	34.4	9.5	10.0	44	41	29	10	27	36
Illinois	1,089	1,220	12.2	12.0	9.8	10.9	4	6	40	47	24	29
Indiana	492	570	10.8	16.0	9.5	10.6	12	13	45	40	27	32
Iowa	349	381	6.9	9.2	12.4	13.1	19	22	49	49	2	4
Kansas	265	301	10.8	13.6	11.8	12.7	27	27	45	44	7	8
Kentucky	336	393	15.1	17.1	10.4	11.2	20	21	35	38	21	26
Louisiana	305	379	27.0	24.1	8.4	9.4	23	24	12	25	39	41
Maine	114	135	7.6	18.6	11.5	12.3	36	36	48	32	9	11
Maryland	298	380	32.3	27.3	7.6	9.2	25	23	8	21	45	44
Massachusetts	633	711	11.3	12.3	11.1	12.3	10	10	43	46	10	12
Michigan	749	887	18.0	18.4	8.4	9.6	8	8	25	34	39	39
Minnesota	407	470	15.4	15.4	10.7	11.6	15	18	33	41	14	19
Mississippi	221	276	17.0	24.8	10.0	11.[illegible]	30	31	27	24	22	22

Missouri	558	635	11.4	13.7	11.9	13.0	11	11	42	43	6	8
Montana	68	83	5.1	21.1	9.9	10.6	43	43	50	25	23	33
Nebraska	183	204	11.8	11.6	12.3	13.0	34	35	41	48	3	7
Nevada	31	61	70.4	96.6	6.3	8.6	49	47	3	1	49	46
New Hampshire	78	98	15.8	25.9	10.6	11.1	39	40	31	23	19	27
New Jersey	694	843	24.4	21.[illegible]	9.7	11.5	9	9	17	27	25	20
New Mexico	70	109	37.7	54.[illegible]	[illegible]	8.8	42	38	5	5	48	45
New York	1,951	2,115	15.8	8.[illegible]	10.7	12.0	1	2	31	50	14	15
North Carolina	412	571	32.7	38.[illegible]	8.[illegible]	10.2	14	12	7	8	41	35
North Dakota	66	80	13.3	20.5	10.7	12.1	45	44	36	31	14	13
Ohio	983	1,142	11.2	15.0	[illegible].3	10.6	5	7	44	42	32	30
Oklahoma	299	363	20.1	21.5	11.7	12.5	24	25	22	28	8	10
Oregon	226	294	23.5	30.3	10.8	11.6	29	29	19	14	13	18
Pennsylvania	1,267	1,491	12.7	17.7	10.7	12.7	3	4	37	37	14	9
Rhode Island	104	123	16.1	18.6	10.9	13.2	37	37	30	33	12	3
South Carolina	190	269	26.8	41.6	7.3	9.2	32	32	13	7	46	43
South Dakota	80	90	12.5	12.4	12.1	13.1	38	42	38	45	5	5
Tennessee	382	492	24.0	28.8	9.7	11.2	15	15	18	19	25	24
Texas	989	1,302	32.9	31.9	8.8	9.7	6	5	6	13	37	38
Utah	77	106	29.4	37.3	7.3	7.7	40	39	10	9	46	49
Vermont	47	56	8.6	17.9	10.6	11.3	46	49	47	38	19	23
Virginia	364	483	26.6	32.7	7.8	9.3	18	17	14	12	44	42
Washington	320	415	15.4	29.5	9.4	10.6	22	20	33	17	30	31
West Virginia	194	226	12.5	16.6	11.1	12.0	31	34	38	39	10	14
Wisconsin	471	556	17.4	18.1	10.7	11.8	13	14	26	35	14	17
Wyoming	30	36	16.6	20.6	9.1	8.1	50	50	28	30	34	48

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[1] Corrected for errors in number of centenarians.

[2] States ranked in decreasing order; State with largest quantity is ranked 1.

[3] Not applicable.

Source: Based on published and unpublished data, Bureau of the Census.

RESIDENT POPULATION, TOTAL, ALL AGES, AND AGE 65-PLUS, STATES IN RANK NUMBER ORDER, 1979

	Total, all ages				65-plus				
			Percent				Percent		
Rank	State	Number (thousands)	Distribution	Cumulative	State	Number (thousands)	Distribution	Cumulative	Rank
1	California	22,694	10.3	10.3	California	2,316	9.4	9.4	1
2	New York	17,648	8.0	18.3	New York	2,115	8.6	18.0	2
3	Texas	13,380	6.1	24.4	Florida	1,603	6.5	24.5	3
4	Pennsylvania	11,731	5.3	29.7	Pennsylvania	1,491	6.1	30.6	4
5	Illinois	11,229	5.1	34.8	Texas	1,302	5.3	35.9	5
6	Ohio	10,731	4.9	39.7	Illinois	1,220	5.0	40.9	6
7	Michigan	9,207	4.2	43.9	Ohio	1,142	4.6	45.5	7
8	Florida	8,860	4.0	47.9	Michigan	887	3.6	49.1	8
9	New Jersey	7,332	3.3	51.2	New Jersey	843	3.4	52.5	9
10	Massachusetts	5,769	2.6	53.8	Massachusetts	711	2.9	55.4	10
11	North Carolina	5,606	2.6	56.4	Missouri	635	2.6	58.0	11
12	Indiana	5,400	2.5	58.9	North Carolina	571	2.3	60.3	12
13	Virginia	5,197	2.4	61.3	Indiana	570	2.3	62.6	13
14	Georgia	5,117	2.3	63.6	Wisconsin	556	2.3	64.9	14
15	Missouri	4,867	2.2	65.8	Tennessee	492	2.0	66.9	15
16	Wisconsin	4,720	2.1	67.9	Georgia	488	2.0	68.9	16
17	Tennessee	4,380	2.0	69.9	Virginia	483	2.0	70.9	17
18	Maryland	4,148	1.9	71.8	Minnesota	470	1.9	72.8	18
19	Minnesota	4,060	1.8	73.6	Alabama	421	1.7	74.5	19
20	Louisiana	4,018	1.8	75.4	Washington	415	1.7	76.2	20
21	Washington	3,926	1.8	77.2	Kentucky	393	1.6	77.8	21
22	Alabama	3,769	1.7	78.9	Iowa	381	1.5	79.3	22
23	Kentucky	3,527	1.6	80.5	Maryland	380	1.5	80.8	23
24	Connecticut	3,115	1.4	81.9	Louisiana	379	1.5	82.3	24
25	South Carolina	2,932	1.3	83.2	Oklahoma	363	1.5	83.8	25
26	Iowa	2,902	1.3	84.5	Connecticut	356	1.4	85.2	26
27	Oklahoma	2,892	1.3	85.8	Kansas	301	1.2	86.4	27
28	Colorado	2,772	1.3	87.1	Arkansas	300	1.2	87.6	28
29	Oregon	2,527	1.2	88.3	Oregon	294	1.2	88.8	29
30	Arizona	2,450	1.1	89.4	Arizona	289	1.2	90.0	30
31	Mississippi	2,429	1.1	90.5	Mississippi	276	1.1	91.1	31
32	Kansas	2,369	1.1	91.6	South Carolina	269	1.1	92.2	32
33	Arkansas	2,180	1.0	92.6	Colorado	239	1.0	93.2	33
34	West Virginia	1,878	.9	93.5	West Virginia	226	.9	94.1	34
35	Nebraska	1,574	.7	94.2	Nebraska	204	.8	94.9	35
36	Utah	1,367	.6	94.8	Maine	135	.6	95.5	36
37	New Mexico	1,241	.6	94.5	Rhode Island	123	.5	96.0	37
38	Maine	1,097	.5	95.9	New Mexico	109	.4	96.4	38
39	Rhode Island	929	.4	96.3	Utah	106	.4	96.8	39
40	Hawaii	915	.4	96.7	New Hampshire	98	.4	97.2	40
41	Idaho	905	.4	97.1	Idaho	91	.4	97.6	41
42	New Hampshire	887	.4	97.5	South Dakota	90	.4	98.0	42
43	Montana	786	.4	97.9	Montana	83	.3	98.3	43
44	Nevada	702	.3	98.2	North Dakota	80	.3	98.6	44
45	South Dakota	689	.3	98.5	District of Columbia	73	.3	98.9	45
46	North Dakota	657	.3	98.8	Hawaii	70	.3	99.2	46
47	District of Columbia	656	.3	99.1	Nevada	61	.3	99.5	47
48	Delaware	582	.3	99.4	Delaware	57	.2	99.7	48
49	Vermont	493	.2	99.6	Vermont	56	.2	99.9	49
50	Wyoming	450	.2	99.8	Wyoming	36	.1	100.0	50
51	Alaska	406	.2	100.0	Alaska	10		100.0	51

97TH CONGRESS
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REPORT
No. 97-62

PART 1
DEVELOPMENTS IN AGING: 1980

MAY 13 (Legislative Day APRIL 27), 1981—Ordered to be printed

Mr. HEINZ, from the Special Committee on Aging,
submitted the following

REPORT

[Pursuant to S. Res. 353, 96th Cong.]

Chapter 1

ECONOMIC PERFORMANCE AND ELDERLY STATUS, 1980[1]

CHAPTER HIGHLIGHTS

Instability and volatility characterized the American economy during 1980. The year began with the conclusion of the longest period of sustained economic growth during peacetime in U.S. history. This peak in business activity was accompanied by the fastest rate of price advance in more than 30 years and record high interest rates. These developments imposed hardships on a considerable portion of the U.S. population.

I. U.S. ECONOMY PERFORMANCE DURING 1980

The 1980 recession was shorter and somewhat milder than expected. As the year began, many forecasters anticipated the downturn lasting through the end of 1980 with the unemployment rate rising to well above 8 percent of the labor force. Instead, real gross national product (GNP), the market value of all goods and services produced in the United States adjusted for price changes, declined in the only second quarter of the year and rose modestly in the other quarters. The unemployment rate did not climb above 8 percent, and averaged about 7.5 percent in the last half of the year.

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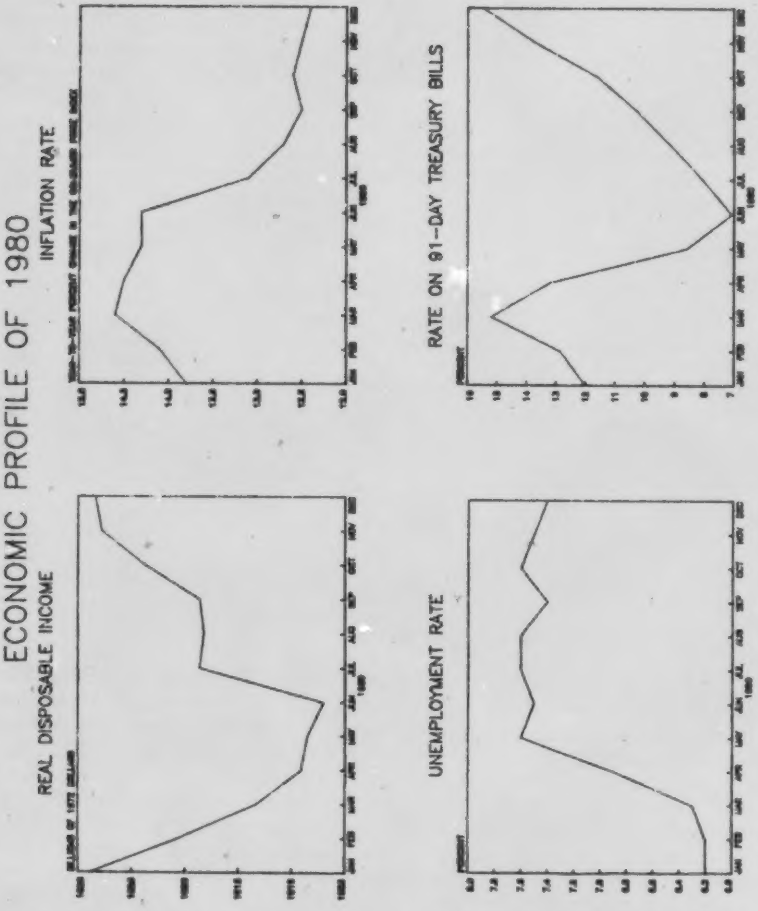
[1] Prepared by the Congressional Research Service, Library of Congress, by the following staff: Tom Gabe, analyst in social legislation, Education and Public Welfare Division; Barry Molefsky, analyst in econometrics, Economics Division; and Ray Schmitt, specialist in social legislation, Education and Public Welfare Division.

Over the past few years, policymakers and economists have tended to underestimate the vigor of the economy. The extent of this misjudgment became evident when the Commerce Department completed an extensive revision of the GNP and its components in December 1980. This revision reflected the availability of new data sources, such as the 1972 input-output tables and the 1977 censuses of business, as well as improved estimating procedures. The new figures show that the economy grew at an average annual rate of 3.3 percent between 1967 and 1979, significantly higher than the 3 percent rate previously reported. More than $60 billion (in 1972 prices) had been added to the level of real GNP. Much of this increase is due to higher estimates of business fixed investment and exports. Statistics on personal income were revised sharply upward as well. This new information suggests that productivity, investment, and savings during recent years were not as poor as previously thought. In addition, the economy was operating much closer to capacity than had been indicated, accounting for the inflationary pressures which confounded policymakers. In short, the economy has been healthier than believed.

Imbalances in the consumer sector and Federal monetary policies are widely believed to have been the major cause of the 1980 recession. Spurred by unusually large increases in prices during the 1975–79 expansion, consumer spending and borrowing advanced at an extremely rapid pace. In effect, households were substituting real assets (homes, automobiles, precious metals) for financial assets. Acquisition of these real assets was financed by borrowing. Consumer installment credit rose by 71 percent, between 1975 and 1979, as personal savings declined from 8.6 to 5.3 percent of after-tax income. The rise in debt also outpaced income gains; disposable personal income grew by just under 50 percent. In the 1980 Economic Report of the President, the Council of Economic Advisors warned:

> The ratio of consumer debt repayments to disposable income has risen steadily in recent years, reaching a record peak of 18 percent in the third quarter of 1979. The increase in this ratio has created concern that consumers are becoming overextended and has also raised fears that a high repayment burden might act as a strong constraint on consumer spending during an economic downturn.



The consumer sector did falter during the early months of 1980 in response to soaring interest rates and the imposition of credit controls. The second quarter slump was concentrated in credit sensitive sectors, particularly housing and motor vehicles. These two areas accounted for nearly two-thirds of the total decline in output. When the cost of money fell sharply between May and August 1980 and credit controls were lifted, the economy began to improve and continued to expand through the end of the year. By the end of 1980, economic indicators, such as industrial production, total employment, and real disposable income had nearly returned to prerecession levels.

Although the economy was in recession during 1980, inflation remained at extremely high levels. The Consumer Price Index (CPI), the most widely used and best known measure of inflation, increased about 13.5 percent compared with an 11.3 percent gain in 1979. Table

1 presents the 1979 and 1980 rates of gain in selected components of the CPI. It should be understood that the CPI is a weighted average of the prices of a representative bundle of goods and services. While it is possible that the prices of all the items included in that typical market basket may be rising at the same rate, it is more likely that some prices will be increasing more rapidly than the average, some prices more slowly, and some prices may even be declining. Moreover, these relationships are not stable; that is, the price of a particular commodity will not always be increasing more rapidly than the average. Price changes of individual items reflect the market conditions for those items.

TABLE 1.—CONSUMER PRICE INDEX

[Percent change from previous year]

	1979	1980
All items	11.3	13.5
Food and beverages	10.8	8.5
Housing	12.2	15.7
Apparel and upkeep	4.4	7.1
Transportation	14.3	17.8
Medical care	9.3	10.9
Entertainment	6.7	8.9
Special indexes:		
Energy	25.2	30.9
All items less food	11.4	14.6
All items less mortgage interest	10.0	11.7
All items less medical care	11.4	13.6
All items less energy	10.0	11.6
All items less food and energy	9.7	12.5

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Energy and housing prices posted large advances in 1980. The energy component of the CPI [2] increased by a staggering 31 percent, primarily due to large rises in the price of imported oil and the phased decontrol of domestically produced crude oil prices. Most of the increases, however, occurred in the early months of 1980. Between June and November 1980, the CPI energy component was virtually unchanged and prices of some specific petroleum products, notably gasoline, actually declined in some months. Excluding the energy component, the all items CPI rose by 11.6 percent in 1980, indicating that nearly 2 percentage points of the total CPI increase was attributable to energy costs.

Sparked by substantial increases in the cost of homeownership, the housing component of the CPI rose by more than 15 percent last year. Over the course of 1980 the housing component fluctuated sharply, reflecting the volatility of mortgage interest rates. Contract mortgage interest costs, which includes interest rates and loan origination fees (points), rose nearly 35 percent in 1980.

The CPI is not the only available measure of price changes, another gage is the implicit price deflator for personal consumption expenditures, which some analysts believe is a more accurate yardstick than the CPI. In theory, these two price indexes are measuring the same thing, prices paid by consumers, and should increase at the same rate. Only rarely, however, do the two behave identically. For example, in 1980 the deflator rose by 10.2 percent, significantly lower than the CPI rise. This primarily reflects the different construction of the indexes. The CPI measures only changes in prices, while the consumption deflator measures changes in both prices and the composition of items purchased. A reconciliation of the rate of change in the CPI and the consumption deflator for the first and second quarters of 1980 is provided in the following table. The table shows the CPI rising much more rapidly than the deflator, mostly due to the differing treatment of homeownership costs.

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[2] This component includes only prices of direct consumer purchases of energy for the home and for motor vehicles.

TABLE 2.—RECONCILIATION OF PERCENT CHANGES IN THE IMPLICIT PRICE DEFLATOR FOR PERSONAL CONSUMPTION EXPENDITURES AND THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS

[Seasonally adjusted]

	1980	
	First quarter	Second quarter
Implicit price deflator for personal consumption expenditures (percent change at annual rate)	12.5	10.6
Less:		
Contribution of shifting weights in PCE	−.5	−.2
New autos	1.3	−4.3
Gasoline and oil	−.5	−.6
Electricity, gas, fuel oil, and coal	−1.0	.7
Furniture and household equipment	−.7	−.4
Food purchased for off-premise consumption	.6	1.3
Purchased meals and beverages	−.3	−.2
Clothing and shoes	−.4	1.0
Housing	.7	2.0
Other	−.3	.3
Contributions of differences in weights of comparable CPI and PCE expenditure components	−1.4	−.1
Gasoline and oil	−1.7	−.5
Electricity, gas, fuel oil, and coal	−.2	−.4
Household furnishings	.2	.2
Food at home and away from home	−.6	.1
Apparel commodities	.2	.1
Rent	−.3	−.3
Other	1.1	.8
Contributions of PCE expenditures components not comparable with CPI components	−1.0	−.5
New autos	−.1	0
Net purchases of used autos	−.1	−.3
Owner-occupied nonfarm and farm dwellings—space rent	−.9	−.3
Current expenditures by nonprofit institutions	.2	0
Other	−.1	0
Plus: Contribution of CPI expenditure components not comparable with PCE components	1.2	2.3
New autos	−.2	−.1
Used autos	−.3	−.8
Homeownership	2.1	3.6
Other	−.4	−.3
Less: Contribution of differences in seasonal adjustment	−.1	0
Equals: Consumer Price Index, all items (percent change at annual rate)	16.9	13.7

Source: Survey of Current Business, August 1980, p. 3.

Government economic policy during 1980 was aimed at reducing inflationary pressures rather than stimulating economic growth. Fiscal policy was relatively restrictive. The Federal budget deficit did balloon to $59.6 billion in fiscal year 1980, but this represents only 2.3 percent of nominal GNP, significantly lower than the percentage during the 1973–75 recession. Moreover, the rise in the deficit was mainly attributable to the automatic stabilizers in the budget (e.g., unemployment insurance benefits) rather than new antirecession spending programs. Unlike during some previous slumps, Federal tax liabilities were not reduced in order to stimulate economic activity.

Monetary policy played a major role in shaping economic developments during 1980. For some time the primary focus of the Federal Reserve has been to slow economic growth and thereby curb rising prices. In recent testimony before Congress, Paul Volcker, Chairman of the Board of Governors of the Federal Reserve System, described the current role of monetary policy. He stated:

> That role requires that the Federal Reserve apply the measured, persistent restraint on growth in money and credit that is necessary to drain the momentum from inflationary forces in the economy and to encourage a return to stability in prices and unit costs.

Preliminary statistics suggest that the Federal Reserve was unable to achieve "measured, persistent restraint" of money growth. Money growth was very uneven over the course of 1980. Between February and May, the narrowly defined money supply, M–1A, declined at an annual rate of 6.2 percent, and rose at a 12.5-percent annual rate between July and November. From the fourth quarter 1979 to the fourth quarter 1980, M–1A rose 5.1 percent, about the same rate of gain as during the preceeding four quarters. This increase was well within the target growth ranges established by the Federal Reserve Board. Growth of the more broadly defined monetary aggregates, however, was around the upper limit of the target ranges.

TABLE 3.—GROWTH IN MONETARY AND BANK CREDIT AGGREGATES

[Percent change]

Item	Actual		Federal Reserve target, 1979 IV to 1980 IV
	1978 IV to 1979 IV	1979 IV to 1980 IV	
M–1A [1]	5.0	5.1	3½–6
M–1B [2]	7.7	7.4	4 –6½
M–2 [3]	9.0	9.9	6 –9
M–3 [4]	9.8	10.0	6½–9½
Bank credit [5]	12.3	7.9	6 –9

[1] M–1A is currency plus private demand deposits, net of deposits due to foreign commercial banks and official institutions.

[2] M–1B is M–1A plus other checkable deposits (negotiable order of withdrawal accounts, accounts subject to automatic transfer service, credit union share draft balances, and demand deposits at mutual savings banks).

[3] M–2 is M–1B plus overnight repurchase agreements (RP's) issued by commercial banks, overnight Eurodollar deposits held by U.S. nonbank residents at Caribbean branches of U.S. banks, money market mutual funds shares, and savings and small time deposits at all depository institutions.

[4] M–3 is M–2 plus large time deposits at all depository institutions and term RP's issued by commercial banks and savings and loan associations.

[5] Bank credit is total loans and investments plus loans sold at all commercial banks

Source: Board of Governors of the Federal Reserve System.

II. INCOME OF THE AGED [3]

In 1978, the median income of families headed by persons age 65 and over was $10,124—a little over half that of families in which the head was less than 65 ($18,939). The median income of aged unrelated individuals (i.e., persons aged 65 and over living outside a family setting was $4,211, compared to $8,178 for nonaged unrelated individuals.

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[3] Information about the income status of the aged reported in this section comes from the March 1979 Current Population Survey (CPS). Annual income information for 1979 will not be available until spring 1981.

The aged depend heavily upon income from sources other than earnings for their support. In 1978, 16 percent of aged unrelated individuals reported that they had income from earnings,[4] with half having earnings less than $2,505. In comparison, 85 percent of nonaged unrelated individuals reported that they had income from earnings, with half of them earning more than $8,991. Similarly, 48 percent of families with an aged head had income from earnings, compared to 94 percent of the families in which the head was less than 65; the median dollar amount earned was $6,700 and $8,310 respectively.

Social security was an important source of income for the aged. In 1978, slightly over 90 percent of the families with an aged head and aged unrelated individuals had income from this source.[5] The median amount received was $2,998 for aged unrelated individuals and $4,769 for families in which the head was 65 or older. While being an important source of income, social security was not usually the sole source of income for aged families and aged unrelated individuals. Only about 15 percent of aged unrelated individuals and 6 percent of the families with an aged head reported that social security was their sole source of income during the year.

Approximately one-quarter of aged unrelated individuals and two-fifths of the families with an aged head reported that they received income from private or Federal pensions during the year; the median amount received from these sources was $2,397 and $2,999 respectively.

About 12 percent of aged unrelated individuals and 8 percent of the families with aged heads received income from the supplemental security income (SSI) program. Of those receiving income from this source, the median annual payment reported by unrelated individuals was $1,052, and $1,227 for families in which the head was 65 years of age or older.

A large proportion of the aged had income from annuities, dividends, rents, and other periodic sources. Among aged unrelated individuals, 62 percent had income from these sources, with half of these receiving less than $825 over the course of the year. Approximately 70 percent of the families with an aged head had income from these sources, with half of these receiving less than $1,201.

In 1978, 13.9 percent of the approximately 23,175,000 persons age 65 and over had incomes less than the official poverty line.[6] The incidence of poverty was higher for the "very old" (age 85 and over) (19 percent) than for those who were between the ages of 65 and 74 (11.6 percent). The incidence of poverty was higher for aged families (16.7 percent) than for aged males (10 percent). The black aged had a poverty rate (33.9 percent) nearly three times higher than that of the white aged (12.1 percent). Aged persons living within a family setting had a lower incidence of poverty than aged unrelated individuals. About 7.6 percent of the aged who lived in families were poor, compared to 27 percent of those who lived outside a family setting.

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[4] Earnings refer to money wages and salaries, and net income from farm and nonfarm self-employment.

[5] Includes railroad retirement benefits.

[6] In 1978, the Census ("Orshansky") Poverty index was $3,217 for a single person age 65 and over, and $3,944 for a couple in which the head was age 65 or over.

INCOME OF AGED AND NONAGED FAMILIES AND UNRELATED INDIVIDUALS, 1978

[By source and median dollar amount received]

Income source and median dollar amount	Families		Unrelated individuals	
	Head less than 65	Head age 65 and over	Less than 65	65 and over
Total	49, 293, 829	8, 510, 153	17, 253, 571	7, 610, 354
Median income	$18, 939	$10, 124	$8, 178	$4, 211
All sources	49, 029, 444	8, 492, 609	16, 516, 181	7, 588, 173
Percent of total	99. 5	99. 8	95. 7	99. 7
Median dollar amount received	$18, 978	$10, 148	$8, 632	$4, 218
Earnings [1]	46, 445, 765	4, 089, 751	14, 592, 822	1, 238, 430
Percent of total	94. 2	48. 1	84. 6	16. 3
Median dollar amount received	$18, 310	$6, 700	$8, 991	$2, 505
Sources other than earnings	37, 411, 209	8, 394, 182	10, 921, 474	7, 528, 522
Percent of total	75. 9	98. 6	63. 3	98. 9
Median dollar amount received	$1, 002	$7, 031	$560	$3, 926
Public assistance [2]	3, 271, 787	205, 314	408, 699	104, 910
Percent of total	6. 6	2. 4	2. 4	1. 4
Median dollar amount received	$2, 120	$1, 441	$1, 562	$443
Supplemental security income	910, 929	689, 718	419, 487	923, 388
Percent of total	1. 8	8. 1	2. 4	12. 1
Median dollar amount received	$1, 552	$1, 227	$1, 805	$1, 052
Social security, railroad retirement	5, 456, 836	7, 829, 884	1, 335, 173	7, 036, 975
Percent of total	11. 1	92. 0	7. 7	92. 5
Median dollar amount received	$3, 069	$4, 769	$2, 562	$2, 998
Private and Federal pensions	3, 012, 508	3, 325, 581	723, 325	1, 913, 547
Percent of total	6. 1	39. 1	4. 2	25. 1
Median dollar amount received	$4, 622	$2, 999	$2, 964	$2, 397
Veterans payments, unemployment compensation, workman's compensation	7, 301, 395	798, 391	1, 780, 090	600, 184
Percent of total	14. 8	9. 4	10. 3	7. 9
Median dollar amount received	$999	$1, 390	$933	$1, 078
All other sources [3]	30, 192, 286	5, 966, 521	8, 789, 249	4, 728, 111
Percent of total	61. 2	70. 1	50. 9	62. 1
Median dollar amount received	$300	$1, 201	$175	$825

[1] The sum of money wages or salary, and net income from farm and nonfarm self-employment.

[2] Public assistance payments such as aid to families with dependent children and general assistance. Separate payments received for hospital or other medical care (vendor payments) are excluded from this item.

[3] Includes: Annuities, alimony, regular contributions from persons not living in the family, and other periodic income.

Note: Table prepared by CRS. Figures are based upon the resident noninstitutionalized civilian population, and the noncivilian population who were not living in military barracks. Figures are subject to sampling error. Cell counts greater than 75,000 have approximately a 95-percent chance of being accurate within 20 percent. Cells with lower counts will have less accuracy.

Source: March 1979 Current Population Survey (CPS).

A. Social Security [7]

An automatic cost-of-living adjustment or "escalator" provision was added to the social security program in the Social Security Amendments of 1972, with the first automatic adjustment taking effect in July 1975. In each of the 6 years, 1975 through 1980, benefits have been automatically increased, since the Consumer Price Index (CPI) increased by at least 3 percent during the measuring period preceding each of these increases. An automatic increase is "triggered" for July of a given year if the CPI has increased by at least 3 percent from the first quarter of the previous year to the first quarter of the current year. Thus, there is, on average, a 10- to 11-month lag between the time the loss of purchasing power takes place and the time when benefits are correspondingly increased. Semiannual increases would reduce this lag time to 7 to 8 months, but would increase program costs by several billion dollars annually. Social security benefits were increased by 14.3 percent in July 1980 because the CPI increased by 14.3 percent between the first quarter of 1979 and the first quarter of 1980. Supplemental security income (SSI) benefits paid to the elderly and the disabled are indexed in exactly the same way, and therefore those benefits also increased by 14.3 percent in June 1980.

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[7] This section was prepared by Nancy Miller, Income Maintenance Section, Education and Public Welfare Division.

Although the cost-of-living escalator continues to serve its original objective of preserving the purchasing power of social security benefits that would otherwise be eroded by inflation, the size of recent automatic increases has stimulated a great deal of comment and reevaluation of the automatic benefit increase provision as it operates in current law. Ironically, one of the reasons why an automatic benefit increase provision was introduced was in hopes that it would hold down the cost of the programs by eliminating the need for Congress to enact ad hoc increases from time to time—increases which were liable to exceed the actual increase in the CPI since the previous ad hoc adjustment. The 14.3-percent increase in July 1980 by itself added $17 billion to the cost of the social security programs.[8] Not only does this large increase have an effect on the overall Federal budget and on the financial status of the social security trust funds in particular, but it causes some diminished confidence in the system and resentment on the part of current workers, many of whose wages are not keeping pace with inflation. The benefit increase itself may be contributing to inflationary pressures.

Some have suggested that the Consumer Price Index for urban workers may not be the best measure for determining how large benefit increases should be. A number of studies have shown that the elderly have spending patterns systematically different from those of the urban worker population. Consumer Expenditure Survey data from the early 1970's suggest that families with a head of household over 65 spend more of their incomes on food, health care, fuel, and utilities, and less on housing, transportation, and clothing than families in general. Analysis done by the Bureau of Labor Statistics (BLS), however, suggests that an experimental CPI constructed specifically for the elderly would not have yielded results very different from the overall CPI during the years 1973–78. Interestingly, the BLS study showed the cost of living increasing at a slightly lower rate for the elderly than for the population at large, while a more recent study by Data Resources, Inc. (DRI), suggests that the cost of living increased at a slightly higher rate for consumers over 55 than for consumers under 55 during the 1970's. In other words, it is not clear that an alternative CPI constructed around the spending patterns typical of elderly persons would usually result in either higher or lower benefit increases for elderly social security beneficiaries. In addition, using a different price index for elderly and nonelderly beneficiaries might confuse the public and create additional opportunities for administrative error. Other population subgroups might seek special cost-of-living indexes tailored to their typical spending patterns, further complicating the issue.

The CPI now used to determine the amount of the annual benefit increase has also been criticized for overemphasizing the increase in the cost of housing as a component in the overall rise in the cost of living. The Carter budget just released recommends a new way of counting housing costs in the CPI, called a "rental equivalency" measure. Findings from studies to date, however, are so mixed that it simply is not clear that this alternative housing cost measure or any of the others that have been suggested is a better, or more accurate, measure of true cost or that it will result in a consistently higher or lower overall CPI.

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[8] Office of the Actuary, Social Security Administration.

B. PRIVATE PENSIONS

Pension benefits can be significantly affected by inflation both before as well as after retirement. While social security and Federal pension plans are indexed, private pensions generally do not provide automatic cost-of-living adjustments (COLA's) mainly because the costs of doing so are unpredictable and can be extremely high. Surveys show that only a small number of private pension plans have adopted automatic COLA's. Those that do usually have a 3-percent "cap" on any increase. Most pension plans do, however, extend pension increases to their retirees in a number of different ways. Almost always they are either collectively bargained for or else made available at the employer's initiative. These adjustments, however, do not keep pace with the rate of inflation.

Inflation has a relatively greater detrimental impact on a retiree who places greater reliance on a nonindexed or partially indexed pension to maintain a preretirement standard of living. Inflation, in turn, may cause greater reliance to be placed by present and future retirees on social security by lessening the role that pensions play in the overall retirement income scheme.

The combined effects of increases in longevity and early withdrawal from the labor force means a longer interval between the cessation of gainful employment and death. While a considerable number of workers retire early, the trend may be bottoming out. Whether the increase in the permissible mandatory retirement age from 65 to 70 under the 1978 Age Discrimination in Employment Amendments and the relatively high rates of inflation currently being experienced will reverse this trend remains to be seen. Surveys show that continued inflation is expected to have an effect on retirement decisions.

Work disincentives exist for continuing employment beyond age 65. Pension plans are not required to provide additional pension contributions or benefit accruals for service performed after age 65. Although a worker will be entitled to a higher social security benefit through delayed retirement credits, he or she might suffer an "opportunity cost" by not drawing social security benefits at age 65. The effect of these factors on a retirement decision is not clear. Given the prospects of continued double-digit inflation, however, the ability of individuals to maintain their preretirement standard of living will be seriously challenged.

Chapter 2

RETIREMENT INCOME

CHAPTER HIGHLIGHTS

The year 1980 ended and 1981 began with a sizable jump in the payroll tax. Wage earners will have to pay social security taxes on the first $29,700 of income in 1981, up from $25,900 in 1980. The tax rate increases from 6.13 to 6.65 percent for both employer and employees. For those earning over $29,700, the maximum tax paid will increase to a total of $1,975, or $387 more than last year (up 24 percent).

At the same time, retirees under social security will get a better break during 1981 on their outside earned income. Those aged 65 to 71 will be able to earn up to $5,500 instead of $5,000, the 1980 ceiling. Those under 65 will have a $4,080 ceiling on earnings, up from $3,720. Any earnings over these amounts are subject to an offset. For every $2 earned in excess of the limit, $1 in benefits is deducted.

In spite of these significant increases in the payroll tax, the social security system faces serious fiscal crises—both short term and long term.

Election year 1980 revealed an uneasy tension between retired voters dependent upon social security in a double-digit inflation economy, and an American public, whose economic mood had turned conservative, calling for major cutbacks in Government spending and a balanced budget. With social security outlays estimated to make up a substantial percentage of the total national budget, it is certain that efforts to cut spending and reduce deficits will include close scrutiny of the whole social security program.

I. SOCIAL SECURITY: MAJOR CHANGES AWAIT 1981

Although faced with forecasts of short-term cash flow problems and long-term deficits in the social security trust funds, Congress (with a few minor exceptions) avoided tackling these major financial crises. Nevertheless, 1980 proved valuable as a sounding board for possible new directions as several national commissions issued recommendations and the Committee on Aging closed the year with a series of hearings on "Social Security: What Changes Are Necessary?"

A. Short- and Long-Term Financing Issues

Despite 1977 Social Security Amendments designed to insure financial stability for several decades, reports by the Social Security Board of Trustees[1] have pointed to serious short- and long-term problems.

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[1] The Secretaries of Health and Human Services, Labor, and the Treasury, serve as Trustees of the trust funds. The Commissioner of Social Security acts as secretary to the Trustees.

The most recent report from the Trustees issued on June 17, 1980, forecast the following likely events using their "intermediate" assumptions: [2]

—The old-age survivors insurance (OASI) trust fund which pays retirement and survivor benefits will run into cash-flow difficulties in late 1981.

—In 1982, the OASI fund will be exhausted.

—From 1983 to 2010, OASI reserves will increase and then fall off again as the baby boom begins to retire.

—Sometime between 2020 and 2025, OASI funds will become exhausted again.

It is significant to note that early 1980 brought a level of high inflation reaching almost 18 percent. Coupled with rising unemployment, these economic developments only heightened trends that had been noticed earlier. In concluding their report, the Trustees made the following statement:

> The actuarial estimates presented in this report are based upon economic and demographic assumptions which are inevitably subject to considerable uncertainty. The assumptions and estimates that appear in this report were necessarily prepared before the most recent changes in the economy were known. Current evidence indicates that the economy has moved into a recession and is weakening rapidly. Therefore, revised short-range projections will probably be necessary in the near future as more information becomes available about the intensity of the changes in the economy. Over the longer term, uncertainty is, of course, an even more difficult factor. However, the Board believes that the long-range estimates presented in this report will remain useful for a longer period of time because they are less sensitive to changes in the short-range economic conditions.
>
> Over the short term the OASI trust fund will face financial strains requiring policy actions. Without such actions, the OASI fund would be depleted in late 1981 or early 1982, depending on the course of the economy. Reallocation of the

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[2] The payroll tax now provides income for three different trust funds administered by the Social Security Administration: The old-age survivors insurance trust fund (OASI) which is the largest and pays benefits to retirees and their survivors and dependents; the disability trust fund (DI) which pays disability benefits; and the health insurance trust fund (HI) which pays for medicare, part A, or hospitalization. The 1980–81 payroll tax rates were divided as follows among the three funds:

	OASI	DI	HI	Total
1980	4.52	0.56	1.05	6.13
1981	4.70	.65	1.30	6.65

This rate is paid both by the employer and the employee.

In making their projections, the Trustees cover the next 75 years for the OASI and DI trust funds. For the HI trust fund, they cover only the next 25 years.

These future cost estimates are prepared using three alternative sets of assumptions, referred to as "optimistic," "intermediate," and "pessimistic." Most important is the intermediate projection. For each set of assumptions, a different estimate is made for such important variables as mortality, fertility, net immigration, inflation, and others. Projections of this type made so long into the future have a lessening degree of certainty, yet they do furnish insight into later consequences of the existing program and possible changes.

tax rates between OASI and DI would postpone depletion until the latter half of 1982 or early 1983.

Following the year's early high inflation, trust fund news went from bad to worse. Each year the administration updates its budget projections in July. The administration's 1980 "midsession" forecast predicted that the OASI trust fund would be depleted in November 1981.

1. SOLUTIONS TO SHORT-TERM PROBLEMS

During the course of the year, several approaches surfaced to solve the short-term cash-flow problem spelled out by the Trustees. The major proposals were:

- —*Reallocation:* Lower the percent of payroll tax going to the relatively solvent disability insurance (DI) trust fund and add it to the threatened OASI fund.
- —*Interfund borrowing:* Instead of actually changing the rates of the three funds, permit a fund threatened by cash-flow difficulties to borrow from funds that are solvent, then reimburse later with interest.
- —*Borrowing from the Treasury:* Rather than borrow from other funds, permit an endangered fund to borrow from general revenues and pay back the loan with interest after reserves have built up again.
- —*Countercyclical financing from general revenues:* Permit the trust fund to use general revenues to make up losses when high unemployment reduces social security revenue.
- —*Inject general revenues to pay all or part of the health insurance (HI) fund:* A major recommendation of the 1979 Advisory Council on Social Security, this proposal, by substituting general revenue funds for part or all of HI, would permit either the payroll tax to be reduced or the percent going to the OASI fund to be increased.

2. REALLOCATION AND H.R. 7670

Despite preoccupation with the elections, Congress did see its way clear to reallocate the payroll tax rates between the OASI and the DI funds for calendar years 1980 and 1981. Signed into law by President Carter on October 9, 1980, Public Law 96–403 (H.R. 7670) shifts income from the DI fund to the OASI fund. During 1980, OASI would get an additional 0.19 percent of the payroll tax and DI would get 0.19 percent less. The funds for 1980 could be transferred to OASI retroactively.

During 1981, OASI would get 0.175 percent more money and DI would get 0.175 less. Although this change in the law is largely technical in nature, its bottom-line effect is to "buy time" for Congress to consider more far-reaching legislative adjustments in 1981 to correct the short-term crisis.

The optimum reserve level for any trust fund is generally considered to be equal to 1 year's outlay of benefit payments. If one of the funds falls below an 8- or 9-percent reserve, a cash-flow problem exists. Checks must go out on the third of each month, but the tax comes in throughout the month. The reallocation of rates between OASI and

DI is estimated to insure a reserve of at least 12 percent in each fund through the end of 1981 as indicated in the following tables:

CASH BENEFITS SOCIAL SECURITY TAX RATES

[In percent]

Year	Old law			After H.R. 7670		
	OASI	DI	Total tax	OASI	DI	Total tax
Employer and employee, each:						
1980	4.33	0.75	5.08	4.52	0.56	5.08
1981	4.525	.825	5.35	4.70	.65	5.35
Self-employed persons:						
1980	6.01	1.04	7.05	6.2725	.7775	7.05
1981	6.7625	1.2375	8.00	7.025	.975	8.00

END-OF-YEAR CASH BENEFIT FUND BALANCES

[As a percent of following year outgo]

Year	Old law			After H.R. 7670		
	OASI	DI	Combined funds	OASI	DI	Combined funds
1980	15	44	18	18	20	18
1981	6	61	12	12	13	12

Note: Estimated by Social Security Administration actuaries.

Notwithstanding the passage of H.R. 7670, Congress must face up to additional changes in the law during 1981 if an impending cash-flow crisis is to be averted in 1982.

3. SOLUTIONS TO THE LONG-TERM DEFICIT

Although it seems almost certain that Congress will find solutions to the short-term cash-flow problem in 1981, it is not certain what action, if any, will be taken to relieve the much more serious long-term deficit facing the system in the 21st century.

The nature of this deficit is the result of several factors working together that suggest serious problems beginning as soon as the year 2010.

—*Increase in aged population:* The 1980 census will count some 25 million persons aged 65 and older, or roughly 11 percent of the population. By the year 2000, the Census Bureau predicts an increase to 32 million (or 13 percent). But when the baby boom (following World War II) reaches age 65, the impact will be even more dramatic. By the year 2030, it is estimated that the 65-plus age group will have grown to 50 million (or 22 percent).

—*Life expectancy:* Today, people are living, on the average, almost 3 years longer after age 65 than they did in 1940, when life expectancy at age 65 was 12 years for men and 13.6 years for women. Social Security Administration figures show that in 1975, life expectancy at age 65 increased to 13.6 years for men and 17.7 years for women, and by the year 2050, the years after 65 are expected to increase to 15.1 years for men and 19.7 years for women.

—*Labor force participation:* Recent years have indicated a growing trend toward earlier retirement by American workers. Between 1950 and 1979, the percentage of male workers remaining in the labor force after age 65 dropped from 39 to 20 percent. For male workers between the ages of 60 and 64 the average dropped from 79 percent (1950) to 62 percent (1979). The comparable rates for women increased between 1950 and 1970, but seemed to level off thereafter.[3]

Since social security is a pay-as-you-go system, with the benefits paid out each month funded by the payroll tax paid in by active workers, the ratio of workers to retirees takes on great significance. This ratio is commonly referred to as the dependency ratio. According to the intermediate assumptions of the Social Security Administration there are 31 beneficiaries for every 100 workers today—a ratio of roughly 3 recipients to every 1 worker. By the year 2030, that ratio may reach 2 to 1.

According to the 1980 Trustee's report mentioned above, under each set of their assumptions, the estimated payment of benefits (as a percent of taxable payroll) increases rapidly after the year 2000. Without changes in the program, these projections forecast severe financial difficulties in the next century.

Using intermediate assumptions, the OASDI trust fund balances would be exhausted by the year 2030; under the pessimistic assumptions, OASDI balances would be exhausted between the years 2010 and 2015. The following chart illustrates these predictions.

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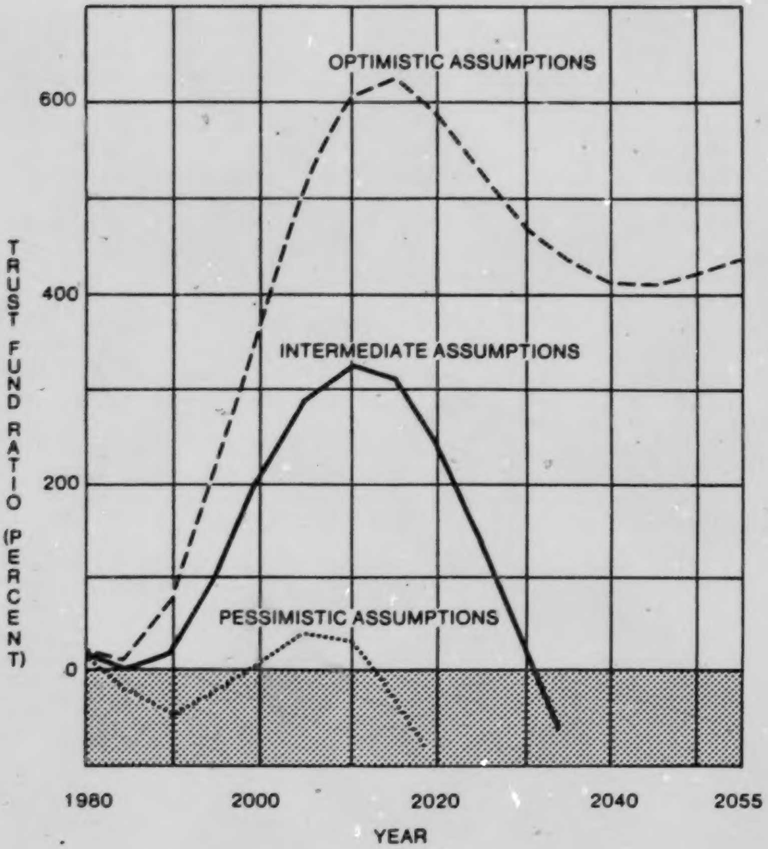
[3] U.S. Bureau of the Census. "Census of Population. Detailed Characteristics. Employment and Earnings." U.S. Department of Labor. January 1971, January 1979, January 1980.

OASDI TRUST FUND RATIOS PROJECTED 75 YEARS



Source: June 1980 OASDI Trustees' Report projections.

Unfortunately, there is no easy way to resolve the long-term deficit problem. Broadly speaking, the only options available are raising taxes, cutting benefits, or some combination of the two. Long-term solutions that have received the most attention in 1980 are listed below.

4. RAISE THE RETIREMENT AGE FOR FULL BENEFITS FROM 65 TO 68

Based partly on the reasoning that life expectancy after age 65 is rising, most versions of this proposal would phase in over 12 years a new eligibility age of 68 beginning after the year 2000. By making the change now to phase in later, most workers would have at least 20 years to plan accordingly. Under this approach, the age of eligibility for reduced benefits would rise in a similar fashion from 62 to 65.

5. CAP OR ALTER THE PRESENT COST-OF-LIVING ADJUSTMENT BASED ON THE CONSUMER PRICE INDEX

The Secretary of Health and Human Services can increase the value of social security benefits each June whenever the cost of living as measured by the CPI has risen 3 percent or more between the first quarter of the previous year and the first quarter of the current year. In 1980, the increase was 14.3 percent. The impact on the national budget of this cost-of-living adjustment (or COLA) has become significant. It is now estimated that each increase of 1 percent in the COLA results in a cost to the budget of from $1 to $1.2 billion.

Several proposals to alter or limit this automatic COLA have been discussed including: (1) Cap the COLA at less than 100 percent of the rise in the CPI; (2) limit the increase to the rise in prices or wages whichever is lower; (3) alter the CPI to change the way in which the increase in the cost of housing is determined;[4] and (4) limit the COLA in years when the CPI has risen faster than wages and provide for retroactive "catchup" in future years when wages again rise faster than the CPI.

6. SWITCH FROM WAGE INDEXING TO PRICE INDEXING

In determining initial benefits to be awarded, a rather complicated formula is used. In applying this formula, average earnings of a worker are indexed, or adjusted, to reflect today's wages. Under present law, this adjustment is based on the increase in average wages.[5]

Because historically wages have grown faster than prices, price indexing would be less expensive and would result in significant long-term savings to the trust funds. One estimate states that since 1950, wages have grown at a rate of 330 percent, whereas prices have grown at only 218 percent.

While price indexing of initial benefits would lower expected benefits in the future, workers would still be guaranteed that their benefits would purchase the same level of goods as would the benefits of workers today with comparable wage records.

However, shifting to price indexing would, over the long run, substantially reduce the replacement rate (the proportion of a worker's recent earnings that are replaced by his social security benefit). For example, it is estimated that the replacement rate for the average worker retiring at age 65 will drop from about 41 percent today to 30 percent by 2010 and to 25 percent by 2050.

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[4] Many economists have argued that the CPI overstates the level of inflation because of how the costs of homeownership are measured. The combined cost of purchasing housing and financing this purchase make up almost 28 percent of the CPI. Because very few people purchase a home during any measurement period, it is argued that recent increases in home and mortgage interest costs do not accurately reflect true inflation for the vast majority who have not purchased homes during this period.

On the other hand, elderly households spend a larger percentage of income on necessities such as food, energy, and health care, the cost of which has been rising faster than the CPI. Therefore, in some ways, the CPI may understate the effect of inflation on elderly budgets.

[5] For more detailed discussion of the complicated issue, see the testimony of Robert J. Myers, "Social Security: What Changes Are Necessary?", hearings before the U.S. Senate Special Committee on Aging, Dec. 2, 1980.

7. USE OF GENERAL REVENUE FUNDING

Similar to one of the short-term solutions discussed above, injecting general revenue funds into traditional social security programs could be designed to alleviate substantially the long-term deficit.

Former Commissioner of Social Security Robert M. Ball recommended such a plan, where one-half of the health insurance (HI) program would be funded by general revenues. At the same time he would keep the 1981 payroll tax rate constant at 6.65 percent, but would increase the combined OASDI portion from 5.35 to 6 percent. Under this approach, Ball predicts that additional tax increases now scheduled could be eliminated and the trust funds would be in good shape into the next century. The 6-percent rate for OASDI would quickly build up contingency reserves to reasonable levels. However, at some point after 2000, the OASDI rate would need to be raised to a rate of 7–7.5 percent to meet the costs now estimated by "intermediate" assumptions.[6]

B. AGING COMMITTEE HEARINGS—"SOCIAL SECURITY: WHAT CHANGES ARE NECESSARY?"

Anticipating the necessity for Congress to address social security financing issues in 1981, Committee Chairman Lawton Chiles and Ranking Minority Member Pete V. Domenici completed a series of four hearings in November and December 1980 entitled: "Social Security: What Changes Are Necessary?"

In announcing the hearings, Senator Chiles stated:

> Resolving the short- and long-range financing problems of social security must be a top priority for the 97th Congress. It is time to make the necessary hard decisions, and to restore full confidence in America's most popular and successful domestic program.

Joining Senator Chiles in stressing the urgency of the issues confronting the program, Senator Domenici added:

> I am particularly concerned that Congress and the American public be as well informed about these issues as possible. By structuring our hearings carefully, I believe the Committee on Aging is ideally suited to bring new information to light and to crystallize the differences between competing viewpoints.

1. INFORMATION PAPER SUMMARIZES RECENT RECOMMENDATIONS

As part of its effort to share as much information as possible on the emerging issues, the committee published a paper entitled: "Summary of Recommendations and Surveys on Social Security and Pension Policies." During 1979 and 1980, several reports and national surveys were released bearing directly on current issues in social security. These reports and surveys received much attention in the national press and stirred great interest in the American public, particularly with senior citizens and those nearing retirement.

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[6] See testimony of Robert M. Ball, "Social Security: What Changes Are Necessary?", hearings before the U.S. Senate Special Committee on Aging, Nov. 21, 1980.

The information paper summarizes the major recommendations and survey findings of these groups and condenses them into a single reference document. The reports summarized were:

—Report of the 1979 Advisory Council on Social Security.

—An Interim Report From the National Commission on Social Security.

—Report of the Universal Social Security Coverage Study Group.

—Social Security and the Changing Roles of Men and Women.

—1980 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds.

—An Interim Report From the President's Commission on Pension Policy.

—Preliminary Findings of a Nationwide Survey on Retirement Income Issues (Market Facts, Inc.).

—1979 Study of American Attitudes Toward Pensions and Retirement (Louis Harris & Associates).

—A Nationwide Survey of Attitudes Toward Social Security (Peter D. Hart Research Associates, Inc.).

2. SUMMARY OF HEARINGS

Not surprisingly, witnesses at the four hearings focused much of their testimony on possible solutions to the short-term cash-flow crisis and to the long-term deficit problem (see discussion of these issues above). In addition, the committee received up-to-date reports from many of the groups which have been created to study social security and related issues. Briefly summarized, the hearings highlighted the following testimony:

—*November 21, 1980:* A panel of national experts, including former Social Security Commissioner Robert M. Ball and Chairman of the 1979 Advisory Council on Social Security Henry Aaron, discussed solutions to the long-term deficit.

—*December 2, 1980:* Witnesses focused on possible changes in the cost-of-living adjustment and the proposed change from wage to price indexing in determining initial benefits. In addition, the effect of inflation on the elderly was discussed, and an update from the President's Commission on Pension Policy was presented.

—*December 3, 1980:* A panel of representatives from six national organizations representing a wide spectrum of constituencies of the elderly shared their views on many of the major proposals for revising the program that had been raised at the earlier hearings.

—*December 4, 1980:* Beginning with a panel representing national survey opinion firms sharing the results of their polls seeking American attitudes on social security issues, the hearings concluded with testimony from William J. Driver, Commissioner, Social Security Administration.

In addition to the four hearings held in Washington, which focused primarily on various aspects of social security, Senator Nancy Kassebaum chaired a hearing, on November 8, in Leavenworth, Kans., on the adequacy of retirement income from several benefit systems. This hearing, entitled "Retirement Benefits: Are They Fair and Are They Enough?", examined how inflation, demographic changes, and scarce resources will impact on social security, the railroad retirement system, the civil service retirement system, various military retirement programs, and tens of thousands of private pension plans across the country. The witnesses, who interacted with one another on a panel, included local representatives of retiree groups, State, and Federal officials.

C. TAXING SOCIAL SECURITY BENEFITS

On December 7, 1979, the 1979 Advisory Council on Social Security released its report of recommendations covering many areas of social security. No recommendation caused more uproar in 1980 than the Council's suggestion that "half of social security benefits be included in taxable income for Federal income taxes." The fallout from this announcement, and its likely misinterpretation (some thought half their benefits were to be cut), was felt quickly on Capitol Hill.

An avalanche of letters and telegrams arrived in Washington attacking this immediately unpopular notion. In response, both the House and the Senate passed resolutions opposing the tax. S. Res. 432, passed by the Senate on August 4, 1980, and H. Con. Res. 351, passed by the House on July 21, 1980, expressed the sense of each House that the 96th Congress would not enact legislation changing the tax treatment of social security benefits.

The reasoning behind the Advisory Council's tax recommendation arguably made sense, despite its cold reception. Present tax treatment of social security was established not by law, but by rulings of the Bureau of Internal Revenue in 1941. As a result, social security benefits are not taxable today.

The Council felt that this treatment was wrong, that social security benefits should be treated to resemble more closely the way other pension income is treated. A recommendation to tax *half* the benefits was based on the grounds that the employee is already taxed on his contribution, but the other half is paid by his employer, and the worker is not taxed on that portion.

As measured by the Council, only a limited number of recipients would be affected by their recommendation:

> Because of the double income tax exemption for the elderly, almost no persons or couples over age 65 today would pay any additional income tax under the Council's proposal if social security were their only source of income. For example, if this provision were in effect in 1979, an aged couple would not be subject to any additional tax unless its total income, including the taxable half of its social security benefits, exceeded $7,400 per year. If the couple's only income were from social security, its benefits would have to exceed $14,800 before any tax would be payable. This is an amount higher than any couple retiring at age 65 in 1979 can receive.

Based on 1978 data, the Council estimated that taxing half of the benefits would affect 10.6 million tax-filing units (those with the highest taxable incomes) of the 24.2 million who received social security cash benefits. On average, the tax increase for these units would be $350 and the increase in Federal revenues would be $3.7 billion.

Based on the very negative reception this idea received from the public, its future legislative opportunities for action appear slim; however, one should note that the House and Senate resolutions passed in 1980 do not bind future Congresses.

D. THE EARNINGS LIMITATION AND H.R. 5295

Amendments to the Social Security Act passed in 1977 (Public Law 95-216) gradually liberalized the earnings limitation for social security beneficiaries and replaced the monthly earnings test with an annual test. Beginning January 1, 1981, beneficiaries over age 65 may now earn $5,500 before any reductions apply. Those under age 65 may earn up to $4,080. Any beneficiary earning over these amounts is subject to a reduction of $1 for every $2 earned over the limit.

Efforts by the 96th Congress to eliminate the earnings limitation altogether did not succeed; however, several changes to the earnings limitation were passed as part of H.R. 5295 (Public Law 96–473).

Prior to the 1977 amendments, the earnings limitation test was applied on a monthly basis. Regardless of annual income, a beneficiary could receive benefits as long as his or her monthly income did not exceed one-twelfth of the annual limit. The 1977 amendments removed the monthly test and replaced it with a stricter annual test, except for one "grace" year. Under the "grace" year exception, each person is entitled to apply the monthly test for the *first* year in which the individual has a month for which he or she is entitled to a social security benefit and where in that month, he or she earns less than one-twelfth of the annual exempt amount and does not perform substantial services in self-employment.

The elimination of the monthly retirement exception had a number of unanticipated results. Several classes of beneficiaries were inadvertently harmed by this change, and H.R. 5295 corrected these unintended effects:

—*People receiving child's benefits (including student's) and those under age 62 receiving mother's, father's, or wife's benefits:* The elimination of the monthly test had harsh results for those who moved in and out of the labor force. Benefits paid earlier in the year often became overpayments and had to be repaid from earnings later in the year. For this group, the monthly test is restored for the year (or each year) in which entitlement *ends* and is retroactive to January 1978.

—*People who had used their "grace" period before 1978:* Beneficiaries on the rolls before 1978 who had already used a "grace" year, were not entitled to another one. H.R. 5295 allows these people one year after 1978, and this provision is retroactive to 1978.

—*People whose application for medicare benefits unintentionally trigger the "grace" year:* Following the 1977 amendments, a person who was not retiring, nevertheless had to file for cash benefits in order to establish eligibility for medicare hospital insurance. Thereafter, if this person had an isolated month with low or no earnings, his "grace" year would be triggered, and he would not be eligible later for using the monthly test when he actually retired. The new law allows people to have both hospital insurance protection and to reserve the "grace" year for the year of actual retirement.

—*People receiving income from self-employment based on services performed after entitlement:* Under prior law some self-employed persons (life insurance agents who receive renewal commissions after retirement, farmers whose leftover crops are sold after retirement, business partners who receive partnership income after retirement) lost benefits even though they did not work. The new law excludes from the earnings test self-employment income received after the year of entitlement that is not attributable to services performed after initial retirement.

E. Cost-of-Living Adjustments (COLA's) and the Challenges to the CPI

Since 1975, social security payments have been eligible for automatic cost-of-living adjustments in the first week of July. Increases are automatic whenever the Consumer Price Index (CPI) of the Bureau of Labor Statistics for the first calendar quarter of the current year exceeds the CPI for the first quarter of the previous year by at least 3 percent. The COLA for 1980 was 14.3 percent. The new benefit rates of July 1, 1980, resulting from this adjustment increased payments nationally by $1.3 billion per month for 35.3 million persons. When estimated new beneficiaries are added in, the estimated fiscal 1981 cost to the trust funds will be $16.8 billion. Viewed in another way, each 1 percent rise in the CPI results in an increase to the budget of almost $1.2 billion for social security benefits.

The 14.3-percent increase brought the following average monthly jump in benefits for beneficiaries:

	New average benefit per month	Increase
Retired worker:		
Men	$376.08	$47.11
Women	294.23	36.87
Disabled worker:		
Men	405.21	51.01
Women	296.00	37.22
Spouse of retired worker	170.30	21.34
Widow/widower not disabled	309.42	38.77

The average worker living alone (including men and women) now receives $330 per month (up $41). The average aged couple (both receiving benefits) receives $563 (up $70).

With social security COLA's resulting in budget increases of $16 billion and more, it was not surprising that this process and its measuring device, the CPI, were under close scrutiny by Congress and the administration. However, early suggestions by the administration to "cap" the CPI increase at 85 percent (or lower) met stiff resistance.

The growing cost and importance of the social security COLA has raised several concerns: (1) Is it fair to give such large increases, 14.3 percent to nonworkers, when the comparable increase in wages (about 9.6 percent in 1980) is less for the workers whose taxes support the system? (2) Is the CPI the appropriate measure for adjusting benefits for inflation? (3) If the CPI is kept as the measuring device, should it be adjusted to reflect more accurately the true rate of inflation?

Many economists have argued that the CPI overstates the rate of inflation. How homeownership is measured lies at the center of this debate. For CPI purposes, the buying of a home and the costs of maintaining it are treated no differently than any other type of purchase. In fact, the price of a home and the cost of financing it make up almost 18 percent of the CPI. Critics of the CPI argue that most people do not purchase homes frequently. Therefore, the relative weight given to these costs distorts the inflation experience encountered by the typical consumer.

With a more conservative administration and Congress, it is almost certain that the issue of social security COLA's and the appropriateness of using the CPI will receive a great deal of attention in 1981.

F. PRESIDENT'S COMMISSION ON PENSION POLICY: INTERIM REPORTS AND SOCIAL SECURITY

During 1980, the President's Commission on Pension Policy issued two interim reports which made several recommendations affecting social security. Created in 1978, the Commission is conducting a 2-year study of the Nation's retirement income policies.

The Commission's first interim report was released in May and included several tentative recommendations bearing directly on social security (see private pension section below for other recommendations). Perhaps central to their early analysis was concern over the development of a "two-class system of retirement in this country."

In announcing the first interim report, Commission Chairman C. Peter McColough (chief executive officer of Xerox Corp.) stated:

> One class of retirees does fairly well in retirement because they receive pension benefits from their employer, if he maintains a pension plan, and they also receive a social security check. The other class of retirees exists at or near the poverty line while relying almost exclusively on social security.

The May recommendations included the following:

—Contributions to and benefits from social security should receive the same tax treatment as do those of other retirement programs. This proposal would mean that income taxes on contributions to social security eventually would be deferred and benefits from social security would be counted as income subject to taxation.

—If the Commission recommendation on tax treatment of social security benefits is adopted, then the social security earnings test should be removed. The Commission staff was asked to study the cost implications of eliminating the test.

—After an appropriate transition period, the social security system should use an earnings sharing approach with at least some inheritance of a deceased spouse's credits by the survivor.

—The Commission expresses strong sentiment in favor of extending social security coverage to all new workers who otherwise would not be covered, but the staff is to present data showing the effects of alternatives to universal coverage that would remedy the windfall benefit and gap problem.

—The normal retirement age for social security should not be raised now out of recognition that there is a social contract with working people today who are approaching retirement age. However, the Commission has seriously considered whether the social contract with future generations of retirees should be changed and concludes that it is preferable to set the normal retirement age in terms of the proportion of adult life to be spent in retirement rather than in terms of an arbitrary age.

In their second interim report issued in November, the Commission repeated their concern over the "two-class" system of retirement and supported the principle that "a balanced program of social security, employee pensions, and individual savings should be available to all workers." Several disturbing facts were highlighted in the November report:

—In 1978, the average income of those age 65 and over receiving only social security was $5,556 for married couples and $2,688 for single persons.

—In 1978, the average total income for those with employee pensions was $10,000.

—Only 42 percent of all private sector workers are protected by pensions in their current jobs.

—A meager 23 percent of all private industry employees are actually eligible (vested) for pension benefits.

Major recommendations from the second report were:

—A normal retirement age of 68 should be phased in over a 12-year period beginning in the year 2000. This change should be adopted now to provide advance warning to younger workers that there will be a gradual move upwards.

—Social security benefits, once received, should continue to be fully adjusted to increases in prices. A separate price index for the elderly might be more appropriate. The Commission rejects indexing benefits by wages instead of the CPI, and it rejects only partial indexation (or capping).

The Commission rejected proposals to switch from wage indexing to price indexing in determining initial benefits; to change the current deferred retirement credit (now set at 1 percent and growing to 3 percent in 1982); and to separate explicitly the adequacy and equity functions of social security.

G. REPORT OF UNIVERSAL SOCIAL SECURITY COVERAGE STUDY GROUP

Created by the 1977 amendments to the Social Security Act, the Universal Coverage Study Group was charged by law to examine the feasibility and desirability of extending social security coverage to uncovered employees of Federal, State, and local governments and of nonprofit organizations.

Issued on March 24, 1980, the final report contained no specific recommendations, but it did provide a careful analysis of a variety of alternatives including their costs and benefits. Four major options were discussed in the report, and they are summarized below:

MANDATE COVERAGE

> Social security coverage would significantly improve the protection provided to public employees and their dependents against income losses caused by disability or death. It would also guarantee that at least some percentage of anticipated retirement income would be fully portable from job to job throughout a career. In addition, many State and local government employees would benefit from higher adjustment of their pensions to compensate for cost-of-living increases when they are no longer working.
>
> Against these advantages, many employees express concern that the relatively generous retirement income from their public retirement systems would be threatened by any proposed coordination with social security coverage. However, under options that are developed later in another part of the report, many employees would reap the benefits of mandatory coverage and would receive retirement income equal to or greater than the income they would have received under the current system.
>
> Mandating social security coverage for all employment would resolve the windfalls and gaps issues most effectively. Initially, however, mandatory coverage on an incremental basis might be preferred. If so, several possibilities for coverage exist.
>
> Coverage could be extended to all or only one of the major noncovered sectors, and directed toward only new employees or to all or some of the current workers within those sectors. Congress could choose to mandate coverage immediately for one group but to phase it in for the others.
>
> Moreover, Congress could select different methods of mandating coverage for different groups. For example, Congress might extend coverage to Federal employment; both the Government and Federal workers would pay the payroll tax. In extending coverage to State and local employees, however, Congress might decide—either on the basis of constitutional implications or on the basis of one government's respect for another's jurisdiction—not to require State and local governments to pay the employer's share of the tax. Coverage could then be extended to these employees by treating their social security payments the way payments of self-employed individuals are treated. This might require a revision of the self-employment tax to prevent the creation of new inequities.

INCREASE INCENTIVES FOR VOLUNTARY COVERAGE

Another option is to establish more widespread coverage through voluntary participation. Pragmatically, this option is relevant only to State and local governments and to private, nonprofit organizations. If Congress approved coverage for Federal employees, directly implementing coverage would be more sensible than encouraging voluntary participation.

Voluntary coverage could be encouraged if social security revenues were raised by means other than, or in addition to, the payroll tax. General revenues, a value-added tax, and revenues from a "windfall profits tax" on oil companies have been suggested as potential sources of funds for the social security program. Because the burden of these other taxes would fall equally on covered and noncovered workers, incentives for voluntary participation would increase.

If these other sources of revenue were applied to the program, however, the effects would extend well beyond mandatory coverage issues. Assessing the desirability of the other effects was beyond the scope of the study group's charter.

Making revenue-sharing funds contingent on voluntary social security coverage would be one possible incentive approach. Revenue sharing now amounts to roughly 2 percent of State revenues. But social security coverage may increase total employer-employee retirement system costs by as much as 5 to 10 percent of State and local governments' payrolls. Because retirement systems are not always coterminous with units of government eligible to receive revenue-sharing funds, administering this incentive would be difficult.

Another approach would tie Federal grants-in-aid to social security coverage by requiring all employment subsidized by the grants to be covered. If social security coverage is in the national interest, justifying Federal subsidies of noncovered employment is difficult. The problem with this approach is that the ultimate effects might be felt not by State and local employees but by the persons the grant programs are designed to assist.

REDUCE GAPS AND UNDESIRABLE SUBSIDIES

A third option constitutes an entirely different approach. It would seek to reduce the problems without requiring coverage. Insurance gaps, windfalls, or both could be reduced without full coverage in several ways:

—A system for transfer of retirement credits could be established between social security and noncovered retirement systems. This action would help reduce coverage gaps for most individuals who leave noncovered employment.

—A minimum level of protection could be required by imposing mandatory minimum standards on noncovered retirement systems. This action would at least partially eliminate coverage gaps.

- —The social security benefits of individuals with periods of noncovered employment could be adjusted to remove or reduce windfall benefits.
- —The option to withdraw from social security currently available to State and local government employees could be eliminated. Although this action would not reduce the current gap or windfall problem, it would help prevent it from worsening.

MAINTAIN THE STATUS QUO

The final option is to do nothing, to maintain the status quo. The study group found no support for continuing the status quo in regard to windfalls, and no organization claimed that its members had a right to gain future windfalls. If there were no transitional costs associated with achieving an equitable distribution, maintaining the status quo would hardly be considered.[7]

H. UNEMPLOYMENT COMPENSATION OFFSET TO PENSIONS

On April 1, 1980, legislation went into effect that required all States to "offset," or reduce, any unemployment compensation benefits received by any person who is also receiving a government or private pension, including social security. The unemployment compensation benefit must be reduced dollar-for-dollar by the amount of the pension benefit.

In 1976, the 94th Congress, responding to reports of a variety of abuses of the unemployment insurance program during the 1973–74 recession, enacted legislation to correct such abuses (Public Law 94-566). One element of this legislation—an amendment to section 3304(a) of the Internal Revenue Code of 1954—was enacted to require that older workers who had retired from the labor force should not be eligible for unemployment compensation benefits in addition to their retirement benefits. However, later legislation (Public Law 95–19) delayed the effective date of the offset until April 1, 1980. The delay was at least in part designed to provide time for the National Unemployment Compensation Commission to study the issue and present its findings and recommendations to Congress.

As the effective date drew near, renewed opposition to the offset grew. The 1976 law had not considered carefully the retiree who must return to the labor force because his or her inflation-eroded pension is not sufficient to live on. After returning to work, the unretired worker typically earns new unemployment compensation rights. When this retired-but-working-again older person becomes unemployed, the argument can be made that he or she should not have the newly earned unemployment compensation reduced by some previously earned pension benefit.

In sum, many individuals earn rights to pension benefits from one job and rights to unemployment compensation from a second or later job. Consequently, in early 1980, both the House and the Senate passed bills which would have modified or eliminated the required offset, but differences between the two bills could not be resolved in time, and the 1976 legislation went into effect on April 1, 1980.

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[7] This analysis, taken directly from the report, was prepared by the Congressional Research Service as part of a "Summary of Recommendations and Surveys on Social Security and Pension Policies," an information paper by the U.S. Senate Special Committee on Aging, October 1980, pp. 29–31.

In July–August 1980, Senators Chaffee and Bradley proposed the already passed Senate version of the bill as an amendment to the pending ERISA multiemployer pension reform bill (S. 1076). Strong differences existed, however, between the House and Senate versions of the unemployment compensation amendment.

In fact, although the House and Senate were in virtual unanimity over the ERISA bill itself, disagreement over the unemployment compensation amendment threatened passage of the whole legislative package.

Finally, a compromise remedy to the offset was passed in September 1980, as part of the ERISA reform legislation (Public Law 96–364). The offset (or reduction) of unemployment benefits by the amount of any pension is now required in the United States only in those cases where the pension is established by the "base period employer"—that is, the employer responsible for the unemployment compensation benefit. The "base period" is typically defined by the States as the 12-month period that precedes the day the individual filed for the unemployment compensation.

In short, the States must continue to apply the offset if, in fact, the same "base period" employment would result in both a pension and an unemployment insurance benefit. If the post-retirement work for the same employer does not affect either the eligibility for, or the amount of, the pension, however, the States are not required to make the offset. Also, if the two benefits are not produced by the same "base employment," no offset is required.

The situation is more complex with respect to social security, since two different employers are each likely to have contributed to the same pension system, in this case social security. As a consequence, the new offset rules allow the States—if they choose—to reduce the required offset by an amount equal to any contributions the employee made toward the pension. In the case of social security, where employers and employees contribute equal amounts, States may limit the offset to one-half of the amount of a social security pension received by the individual who also qualifies for unemployment compensation benefits.

It should be noted that unemployment compensation is a State program and the new Federal legislation only requires the State to reduce the unemployment compensation by half of the social security benefit. The State may, however, reduce the unemployment by the entire amount of the social security benefit if it so decides.

I. OTHER ISSUES

1. LIMITATION ON PAYMENT OF RETROACTIVE SOCIAL SECURITY BENEFITS

Prior to passage of the Omnibus Budget Reconciliation Act of 1980 (Public Law 96–499), social security benefits could be paid retroactively for 12 months, if eligibility were determined. The Reconciliation Act reduced the retroactive provisions to a period of 6 months prior to the month in which application for benefits is made. Benefit applications for disabled workers, their dependents and disabled widow(er)s, however will continue to be made retroactively for 12 months.

2. WITHDRAWAL FROM SOCIAL SECURITY COVERAGE

Faced with growing concern over the increasing number of terminations of participation in social security by State and local governments, the Committee on Aging published an information paper entitled: "State and Local Government Terminations of Social Security Coverage" (December 1980). Prepared with the assistance of the Social Security Administration, this paper updates an earlier study released by the committee in September 1976, entitled: "Social Security Coverage: The Impact on State and Local Government Employees." The new report provides an objective assessment of the arguments for and against social security, and it includes an analysis of the withdrawal of the State of Alaska from coverage, as well as a dollars and cents look at the value of social security.

In announcing the release of the paper, former committee Chairman Lawton Chiles stated:

> Anyone considering the option of terminating social security coverage should weigh the pros and cons very carefully. It is my hope that this paper will prove valuable to all those who are faced with this important decision.

II. PRIVATE PENSIONS

The most significant developments in the area of private pensions included efforts to strengthen multiemployer pension plans and the tentative recommendations of the President's Commission on Pension Policy.

A. ERISA and Multiemployer Pension Plan Termination Insurance

After long debate and many delays, Congress finally succeeded in passing legislation to tighten funding requirements and reduce government liability for 2,000 multiemployer pension plans covering 8 million workers.

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA). As part of this legislation, Congress created a self-insurance program to guarantee promised pension benefits for employees covered by single-employer and multiemployer plans. Multiemployer plans are pension plans which are the subject of collective bargaining between employers and unions and to which more than one employer contributes.

Workers in such industries as trucking, coal mining, retail food, construction, and entertainment are frequently covered by multiemployer pension plans under terms of their union contracts. Under ERISA, such plans may not defer funding or reduce benefits to retirees even if employment in their industries declines.

If employment does decline, both employers and employees must raise their premiums to continue funding benefits for workers who have retired, or withdraw from the plans altogether. Because of economic and demographic developments since 1974, employers and active workers in some multiemployer plans are paying a very high price to maintain the often meager benefits of a growing number of retirees.

Because ERISA provided little incentive for companies to retain membership in ailing plans, a mass exodus was possible once the guarantees under ERISA became effective. At that point, ailing companies could shift their pension burden to the Pension Benefit Guarantee Corporation (PBGC), the insuring agency created by ERISA, and thus avoid leaving their retirees without any income. One estimate by the PBGC indicated it might have to fund as much as $4 billion in benefits if all troubled multiemployer pension plans folded—a sum far in excess of its assets. The guarantee corporation is financed through employer-paid premiums, and if too many claims push it into bankruptcy, the taxpayers would have to bail it out.

In recognition of the fact this legislation might need a series of revisions before becoming operative, Congress deferred the mandatory insurance covering multiemployer pension plan benefits until May 1, 1980 (Public Law 96–24). Until that date, the PBGC had discretion to undertake the payment of pension benefits to employees covered by terminated multiemployer plans.

As the date for implementing the provisions of insurance covering multiemployer plans drew near, concern grew that if the provisions of ERISA became effective for multiemployer plans on a mandatory basis, the PBGC would immediately be inadequately funded for purposes of covering anticipated plan terminations. Clearly, some action needed to be taken.

At the request of the administration, H.R. 3904 and S. 1076 were introduced in the House and the Senate. These proposals were designed to replace the multiemployer pension plan termination insurance provisions of ERISA. After several delays, an amended version of H.R. 3904 was signed into law on September 26, 1980 (Public Law 96–364). Among the many provisions of this complex bill were the following major changes:

- *Definition of multiemployer plan:* The definition is changed to provide that a multiemployer plan is a plan to which two or more unaffiliated employers contribute pursuant to collective bargaining agreements. Because the old definition required that no employer contribute more than 50 percent of the total plan contributions and that the plan not provide for certain benefits to be canceled when an employer stopped contributing, some plans previously determined to fall outside the definition now are subject to the multiemployer plan provisions.
- *Definition of insurable event:* The new law changes the insurable event from the termination of a plan to insolvency. The PBGC is required to provide financial assistance to insolvent multiemployer plans (whether or not terminated) where the assistance is needed to enable the plans to pay basic benefits.
- *Higher insurance premiums:* The new law provides that the annual per-participant premium for multiemployer plans is to increase from the present $0.50 to $2.50 over a 9-year period to

assure that the PBGC will have sufficient assets to pay benefits up to the guarantee level for those plans that do become insolvent.

—*Troubled plan:* The law now places certain financially troubled plans in a status of "reorganization." Once a plan enters reorganization, a minimum contribution requirement, which usually requires an increase in employer contributions, applies to the plan. The minimum contribution requirement is phased in to protect employers against very large increases in contributions for a plan year. In the case of a plan considered overburdened because it has a high proportion of retirees, the additional funding required under the minimum contribution requirement is reduced by an overburden credit.

—*Benefit reductions:* Trustees of multiemployer plans in serious financial difficulty may reduce or eliminate benefit increases that have been in effect for fewer than 5 years.

—*Benefit guarantees:* The act includes special benefit guarantee levels for multiemployer plans. Benefits under plans that met certain funding requirements in the 10 years preceding the effective date of ERISA's funding rules are guaranteed at a higher level than benefits under plans that did not meet those requirements. For the former plans, monthly benefits are guaranteed at the rate of 100 percent for the first $5 of the benefit and 75 percent of the next $15. Guarantees for the latter, underfunded plans are set at 100 percent of the first $5 of monthly benefits and 65 percent of the next $15.

—*Supplemental guarantees:* The act directs PBGC to set up a supplemental guarantee program which would allow multiemployer plans that meet certain qualifications to pay an additional insurance premium and obtain greater benefit guarantees.

—*Delinquent contributions:* The act strengthens the ability of trustees to collect delinquent contributions by making the employer's duty to contribute to the plan an obligation under ERISA. Plans that prevail in court actions to recover delinquent contributions will be entitled to receive court costs, attorney fees, interest, and liquidated damages as well.

—*Withdrawing employers:* The law now institutes liability for employers who withdraw from plans that have unfunded vested liabilities. A withdrawing employer's liability is its fair share of the plan's total unfunded vested liability and is to be paid back to the plan in annual installments for a period not exceeding 20 years.

An amendment offered by Senator Pete V. Domenici provides a "grandfather clause" for present pensioners and those very near retirement who would find it very difficult to make alternative provision for financial security in retirement:

> For people who, on July 29, 1980, were (a) receiving pensions, or (b) vested and within 3 years of normal retirement age, benefits at the level in effect on that date are guaranteed up to the limits for single-employer plans (currently, $1,159 a month). That provision does not apply if the plan terminates by mass withdrawal.

B. PRESIDENT'S COMMISSION ON PENSION POLICY MAKES INTERIM RECOMMENDATIONS

As discussed above in the section on social security, the President's Commission on Pension Policy issued two 1980 interim reports (in May and in November). Besides their recommendations on social security, the Commission made several proposals aimed at improving the private pension system in the United States.

Perhaps their most far-reaching suggestion was that "serious consideration should be given to the establishment of a minimum advance-funded pension system. Such a program could be thought of as an advance-funded tier of social security that would permit contracting out to pension plans that wanted to meet its standards or as a universal, employee pension system with a central portability clearinghouse."

In announcing their first set of recommendations, Commission Chairman C. Peter McColough, who is also chief executive officer of Xerox Corp., pointed out:

> More people are expected to live longer in retirement in future years. Therefore, the problems associated with our enormous pension programs in this country will increase. Steps must be taken soon to address the issues and design solutions to our difficulties in the area. We are convinced of the need for a comprehensive U.S. pension policy.

Other recommendations issued by the Commission included:

—The replacement of preretirement disposable income from all sources is a desirable retirement goal.

—The greatest emphasis should be placed on expanding pension coverage rather than providing full inflation protection to some at this time.

—The tax treatment of employee and employer contributions to pension plans and earnings on these contributions should be the same.

—The concept of a tax credit for low- and moderate-income people to encourage individual retirement saving and employee contributions to plans should be given serious consideration.

III. PUBLIC PENSIONS

A. CIVIL SERVICE RETIREMENT

1980 was not a quiet year for civil service retirees. In addition to rising concerns over the possibility of some type of merger with the social security system, retired civil service workers were also forced to fight off very serious attempts to remove their twice yearly cost-of-living adjustments (COLA's).

The question of "universal coverage," or bringing civil service employees under the social security system, received much attention when the Universal Social Security Coverage Study Group released their final report in March 1980. However, since the Carter administration announced shortly thereafter that they had no plans to take any action, it soon became clear that no serious legislative effort to enact any form of universal coverage was likely in the remaining days of the 96th Congress. With a new administration entering in 1981 and with the elections of 1980 over, renewed interest in universal coverage could emerge.

The issue of reducing to once per year, the twice yearly COLA for Federal, postal, and military retirees was a quite different matter. Originating as part of the Carter budget requests for fiscal year 1981, the move to reduce the twice yearly COLA's was successfully engineered through both the House and Senate Budget Committees.

The move to reduce the COLA's was carefully designed to be part of the mammoth Budget reconciliation bill. Thus, by combining it with a large number of additional cutbacks, legislators were voting to balance the budget by voting for the whole "package" of bills. The many interest groups lobbying to retain their twice-yearly COLA's were naturally anxious to devise a way to force a vote on the COLA issue alone.

After several setbacks in attempting to execute this strategy, their efforts were finally successful. In late August, before the final reconciliation bill was scheduled to go to the House floor for a vote, supporters of the twice-yearly COLA were able to garner enough votes in the House Rules Committee to permit introduction of an amendment on the floor forcing a yes or no vote on the COLA issue. The amendment to retain the double COLA (introduced by Representative Robert Bauman of Maryland) easily won by a vote of 309 to 72.

Largely as a result of this vote, Senate and House conferees eventulaly eliminated any reference to the twice-yearly COLA issue in the version of the Budget Reconciliation Act of 1980 (H.R. 7765).

B. "LOOK BACK" AND "PRORATIONING"

In its final version, H.R. 7765 (Public Law 96-499) did make two alterations affecting the manner in which initial benefits for civil service retirees are calculated.

For several years, upon retirement, civil service workers were able to rely on a provision known as the "look back." The "look back" permitted each retiree to add to his initial retirement benefit the cost-of-living adjustment most recently awarded to civil service pensioners. Under the twice-yearly COLA system, each retiree saw his benefits adjusted each October and each March. Therefore, a worker retiring in late September could "look back" to the previous March 1 and add that COLA to his initial retirement benefit.

On top of the "look back," each retiree was eligible for the full semiannual COLA after he retired. In other words, he could retire on September 30, receive his benefit, and 1 day later (on October 1) be eligible for a cost-of-living adjustment—even though he had only been retired for 1 day. By combining both of these advantageous provisions, any prospective civil service retiree could carefully time his retirement to receive two COLA's virtually at once. For example, a worker retiring in 1980 could have timed his retirement to occur on September 30, 1980. By so doing, his initial benefit would have been increased by 6 percent immediately ("looking back" to the March 1, 1980, COLA), and 1 day later (on October 1, 1980) his new benefit including the 6-

percent COLA would have been increased by 7.7 percent. In short, although retired for only 1 day, the retiree would have received a 13.7-percent increase to his benefit to keep him even with inflation. In effect, he would start 13.7 percent ahead of inflation (about 14.2 percent, considering the effect of the second COLA on the first.)

H.R. 7765 brought a halt to both of these practices. The "look back" is no longer available to civil service retirees, and their first semiannual COLA is now prorated. More specifically, for every month (or every fraction of a month) that a pension was payable prior to the first COLA, the beneficiary is entitled to one-sixth of the new increase. For example, if a retiree had been retired for 3 months when the next COLA became effective, he would be eligible for one-half the increase.

C. Railroad Retirement Pensions

On January 1, 1981, the retirement payroll tax rate for railroad employees increases from 6.13 to 6.65 percent. The payroll tax rate for railroad retirement is the same as for social security and both the rate and the amount of earnings are subject to the tax increase whenever social security taxes rise.

The most central concern of the railroad retirement system is its fiscal soundness. Reports from the Chief Actuary of the Railroad Retirement Board indicate that, based on updated assumptions, the railroad retirement account will become insolvent under current law in 1983, and under more pessimistic assumptions, could run out of funds early in 1982.

Although efforts in the 96th Congress (notably S. 2979) were unsuccessful in shoring up the actuarial soundness of the system it is expected that Congress will take steps to improve the system as it will for social security.

In December 1980, Congress passed H.R. 8195 (Public Law 96–582) which directed both management and labor representatives of the railroad industry to present joint recommendations.

Specifically, the law states:

> No later than March 1, 1981, representatives of employees and representatives of carriers, acting through a group designated by them, shall submit to the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Interstate and Foreign Commerce a report containing their joint recommendations for further restructuring of the railroad retirement system in a manner which will assure the long-term actuarial soundness of such system.

D. Cost-of-Living Increases Extended

The federally administered railroad retirement system consists of two component parts or "tiers." Tier I is designed to be equivalent to social security, and is financed in the same way. Cost-of-living increases to tier I are automatically applied as they are for social security.

Tier II is an amount in addition to tier I and is analogous to a private, employer-paid pension. It is financed by a 9.5-percent payroll tax paid entirely by the railroad employer. The Railroad Retirement Act of 1974 provided for four specific cost-of-living adjustments in tier II. The last of the four specific cost-of-living increases approved by the 1974 law became effective June 1, 1980. No further increases were approved.

However, as part of H.R. 8195, Congress approved an additional, or fifth cost-of-living adjustment, to become effective on June 1, 1981.

E. MILITARY PENSIONS

Prior to the passage of S. 91 (Public Law 96–402), an offset was required for survivors entitled to benefits under the military survivor benefit plan (SBP). Benefits under the SBP payable to a widow age 62 or over, or to a widow under age 62 if she is a mother of one dependent child, were reduced by an amount equal to a social security benefit computed solely on the basis of her deceased husband's military record.

S. 91 does not change the requirement for an offset but limits the maximum amount of the offset to 40 percent of the benefit payable to the spouse under the survivor benefit plan. The 40-percent ceiling on reductions in the Department of Defense payments to the survivor will be of very significant benefit to a substantial number of survivor beneficiaries.

IV. SUPPLEMENTAL SECURITY INCOME

During 1980, a cost-of-living increase of 14.3 percent was added to all supplemental security income (SSI) payments effective July 1, 1980. As mentioned previously, social security and SSI checks increase automatically each year if the Consumer Price Index (CPI) rises by 3 percent or more over a specified period.

As a result of the July increases, the maximum Federal SSI payments increased as follows:

	Old payment	With 14.3 percent increase
Individual	$208.20	$238
Couple	312.30	357

It should be noted that most States provide payments supplementing the Federal SSI payment levels for some or all recipients.

H.R. 8406: NEW TRANSFER OF ASSETS RULE

On December 28, 1980, President Carter signed into law H.R. 8406 (Public Law 96–611) which contains a new "transfer of assets" rule which penalizes applicants for SSI and medicaid who transfer an asset for less than fair market value.

The new law amends section 1613(c) of the Social Security Act by requiring the Social Security Administration to consider as available any asset of an applicant for SSI which has been transferred for less than fair market value in the previous 24 months prior to application,

unless the applicant can demonstrate by "convincing evidence" that the asset was disposed of for reasons other than to obtain eligibility for SSI. In other words, the Social Security Administration must presume that the asset is still available, and the burden of proof is on the applicant to show that the asset was transferred for some other purpose. Applicants who cannot meet this burden of proof will be denied eligibility for a 24-month period from the time of the transfer.

Since the Department of Health and Human Services has not yet issued regulations to implement this new provision, it is uncertain whether this rule will be applied retroactively. For SSI, the new rule takes effect on March 1, 1981. For an application filed after March 1, it is not clear whether the statute permits consideration of transfers, which occurred prior to March 1, 1981. However, the statute should not affect applicants who both transfer an asset and apply for SSI before March 1, 1981.

V. AGE DISCRIMINATION AND MANDATORY RETIREMENT

Although 1980 was not a year of major breakthroughs in the area of age discrimination and mandatory retirement, there were some significant developments. The age of retirement for Foreign Service workers was raised from 60 to 65; Congress expressed its displeasure with the policy of restricting consideration of those over 60 for appointment to the Federal bench; and a significant conflict of interpretation developed between the Department of Labor and the Equal Employment Opportunity Commission (EEOC) concerning the accrual of benefits for workers who continue to be employed after the normal retirement age.

A. FOREIGN SERVICE ACT OF 1980

Signed into law by President Carter on October 17, 1980, the Foreign Service Act of 1980 (H.R. 6790) raised the mandatory retirement age for members of the Foreign Service from age 60 to 65. Retirement benefits are provided for a qualified participant with at least 5 years of service credit under the system, excluding military service.

There are two exceptions to the mandatory age of retirement at 65: (1) Presidential appointees may continue to serve until their stated term ends, and (2) in matters of public interest, the Secretary of State may defer retirement at age 65 for a period up to, but not to exceed, 5 years.

Raising the age to 65 brought additional benefits to Foreign Service workers. Traditionally, in the case of workers who died or became disabled and who had not accrued 20 years of service credit for their retirement, the law provided for automatic accrual of years of credit equal to the difference between the age of the deceased or disabled worker and age 60. Under the new act, years of service credit will be provided to age 65. Thus, for example, a deceased worker at age 55 would be eligible for an additional 10 years of service credit instead of 5.

B. CANDIDATES FOR FEDERAL JUDGESHIPS

Nominees for lifetime appointment to Federal judgeships have in recent years been subjected to a policy which restricted consideration of possible candidates over age 60. This policy was soundly criticized by both the House and the Senate during 1980.

The Standing Committee on Federal Judiciary of the American Bar Association has a policy that states as follows:

> An individual 60 years of age or older is not recommended for an initial appointment to a lifetime Federal judgeship unless in excellent health and evaluated as "well qualified" or "exceptionally well qualified." In no event are persons over age 64 recommended for initial appointment.

The Department of Justice substantially agreed with this policy.

Led by Representative Claude Pepper, chairman of the House Select Committee on Aging, both Houses of Congress expressed their strong opposition to this policy. The Senate version, S. Res. 374, introduced by Senator DeConcini, passed by a vote of 97–0 on April 1, 1980. A similar provision, H. Res. 693, introduced by Congressman Pepper, passed the House on November 17, 1980. The resolutions expressed the sense of each House that the Standing Committee on Federal Judiciary of the American Bar Association and the Attorney General should "take all measures necessary to end discrimination against potential lifetime Federal judges who do not qualify solely as a result of age barriers."

C. EEOC PROPOSALS TO REQUIRE BENEFIT ACCRUALS PAST NORMAL RETIREMENT AGE

The Equal Employment Opportunity Commission (EEOC) proposed changes to the Labor Department's Interpretive Bulletin on Age Discrimination in Employee Benefit Plans that would require benefit accrual and plan contributions for employees who work past the normal retirement age. These proposals were submitted to the Labor Department, the Internal Revenue Service, and the President's Commission on Pension Policy on April 25, 1980.

The Equal Employment Opportunity Commission, which assumed responsibility from the Labor Department for enforcement of the Age Discrimination in Employment Act (ADEA) in July 1979, proposed changes to remedy what it viewed as the inequities older participants experience under the Labor Department's interpretation of the law.

The 1978 amendments to the ADEA raised the mandatory retirement age in private industry from 65 to 70 (Public Law 95–256). The central question at issue in the EEOC's proposals was whether or not employees should be required to accrue additional benefits for employees who continue to work past the normal retirement age.

In short, the Labor Department had said there was no requirement for accrual (final regulations published in the Federal Register on May 25, 1979). The EEOC proposal would make four basic changes in the Labor Department interpretations of the law:

(1) Prohibit employers from excluding from participation in defined benefit plans employees hired within 5 years of normal retirement age.

(2) Require contributions to defined contribution plans for employees who work beyond normal retirement age.

(3) Require the crediting of years of service under a defined benefit plan for years worked after normal retirement age; and

(4) Set up alternatives for actuarial adjustment of benefits for employees who work past normal retirement age.

Following review by the appropriate Federal agencies, the EEOC was preparing to vote on the measure on October 21, 1980. However, a last-minute, 18-page letter (dated October 17, 1980) from Labor Secretary Ray Marshall to EEOC Chairman Eleanor Holmes Norton led to a postponement of the vote. By year's end, the EEOC had put off the issue indefinitely. According to the letter, the Labor Department felt that the EEOC's interpretation of the ADEA was contrary to the legislative history of the act, and conflicted with some of the technical requirements of the Employee Retirement Income Security Act (ERISA).

More specifically, Secretary Marshall argued that employers affected by the proposed changes would be faced with much higher costs in order to fund the benefits required. In the view of the Labor Department, the legislative history of the 1978 ADEA amendments was contrary to the direction proposed by the EEOC. Quoting the Senate report on these amendments (S. Rept. No. 95–493, 95th Cong., 1st sess. (1977), pp. 13–16) the Marshall letter said that the ADEA amendments do not "require the accrual of additional benefits or the payment of actuarial equivalent of normal retirement benefits to employees who choose to work beyond the plan's normal retirement date."

While it remains uncertain what effect the new Reagan administration will have on the issues of accrual of benefits after normal retirement age, clearly the obvious disagreements over legislative history suggest unlikely changes without some form of congressional action.

VI. EMPLOYMENT—NEW HEARINGS: "WORK AFTER 65: OPTIONS FOR THE 80's"

Passage of the 1978 amendments to the Age Discrimination and Employment Act has had a major impact on the issues of aging, work, and retirement. The mandatory retirement age for Federal employees was completely eliminated and the age in the private sector was raised from 65 to 70 (Public Law 95–256). The potential impact of greater employment of the older worker is significant not only for today's older worker, but for the future labor force of the whole Nation.

With the post-World War II baby boom soon to become the senior boom at the beginning of the next century, it is essential to begin exploring new ways to stimulate continued employment for older workers both before and after age 65.

In an effort to shed light on this issue of growing social and economic importance, the Senate Special Committee on Aging initiated a new series of hearings on "Work After 65: Options for the 80's."

Despite sweeping changes in the mandatory retirement law in 1978, there is no hard evidence yet to indicate that substantial numbers of older workers are delaying retirement and working longer.

It is important to bear in mind that, in considering ways of increasing employment opportunities for the older worker, the committee in no way was suggesting that opportunities for early retirement should be eliminated or reduced. For many people, early retirement is both necessary and viable. What is of significant policy concern is that so few alternatives are currently available.

The primary purpose of this new series of hearings is to learn about the problems facing older persons who want to continue to work. A major concern is the future implication of current trends and present policies. It is the committee's view that new efforts to encourage greater opportunities for continued employment of older persons will be both human effective and cost effective.

"Human effective" suggests that we should provide better opportunities for older workers, both before and after age 65, to follow their own desires and preferences, to use their skills, experience, and learning in pursuit of their own financial and psychological independence.

There is a great deal of evidence, from several recent national public opinion surveys,[8] clearly indicating that many older citizens want to continue working: Some prefer full-time work, others prefer part-time employment to supplement their pension and social security benefits, and some, of course, are perfectly happy with full retirement, which is their right. But the general preference for expanded work opportunities is strikingly clear.

The costs of retirement systems are becoming more and more obvious every day. Concern over the financing of the social security system and the threatened collapse of various pension funds are but two examples of the cost problem. Over the past several decades, fewer and fewer older workers have stayed in the active labor force. According to a Department of Labor study in 1947, 48 percent of male workers age 65 and older were in the labor force, a percentage which declined to only 22 percent by 1974. Estimates made prior to the 1978 amendments projected that such participation would drop to 19 percent by 1990.

A growing older population, combined with increased longevity and less and less labor force participation, means an escalating reliance on social security and pension systems, which are already under great financial pressure. What better way is there to ease this problem than by recognizing that millions of older persons prefer to work, and by encouraging job opportunities for them?

The first two hearings in the series were held in Washington, D.C., on April 24, 1980, and May 13, 1980, respectively. On the first day the committee heard from a panel of distinguished experts concerning the economics and the psychology of the older worker. The second hearing heard an equally distinguished panel of corporation presidents and vice presidents whose companies have had successful experiences with older worker policies.

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[8] National Council on the Aging, "The Myths and Realities of Aging in America" (Washington, D.C., 1974); Johnson & Higgins, "Study of American Attitudes Toward Pensions and Retirement: A Nationwide Survey of Employees, Retirees, and Business Leaders" (New York: 1979); Social Security Advisory Council, "A Nationwide Survey of Attitudes Toward Social Security" (Washington, D.C.: 1980); President's Commission on Pension Policy, "Preliminary Findings of a Nationwide Survey of Retirement Income Issues" (Washington, D.C.: 1980); NRTA–AARP, "DataGram": A Periodic Publication of the National Retired Teachers Association—American Association of Retired Persons, 1980.

Despite the somewhat different backgrounds and orientations of various witnesses at these two hearings, two general themes emerged throughout their testimony. These two themes also represent conclusions which appear to have the support of all the witnesses.

First, there is great value both to the worker and to the employer in encouraging employment opportunities for the older worker. While older employees obviously gain from increased income, there is a substantial psychological benefit that is also produced. The older person who desires to work and finds a suitable job has a much more positive feeling about himself and a stronger sense of contribution to his employer and to his community.

Employers who have been in the forefront on this issue, which include the four companies that testified at the second hearing, report no great problems or ill effects from allowing older employees to remain on the job. On the contrary, the witnesses consistently remarked that their older employees were among their most loyal and productive workers. Companies such as Polaroid and Bankers Life & Casualty, which have never had mandatory retirement, are not overrun by thousands of old workers of declining competence. In fact, the corporate witnesses report just the opposite: A self-selection process has evolved in which the less healthy and less motivated employees are typically the first to want to retire, and the competent, motivated employees are the ones who often choose to stay on.

The second major conclusion to emerge from hearings is that older workers are the victims of myths and stereotypes. Dr. K. Warner Schaie, a psychologist who is director of the Gerontology Research Institute of the Andrus Gerontology Center at the University of Southern California, reported results from his 21-year longitudinal study of age changes in competence and learning ability. He concluded that there is no evidence of systematic across-the-board poor health, higher accident rates, lower productivity, reduction in learning ability, or lowered value of retraining as a consequence of normal aging.

At earlier Committee on Aging hearings on "How Old Is Old? The Effects of Aging on Learning and Working," this point was stressed. Carl Eisdorfer, M.D., Ph. D., of the University of Washington School of Medicine, pointed out:

> It is difficult for us to come up with conclusions because one of the few truisms about aging is that the older you get, the larger the variance in the population. That means we have a problem arriving at significance because dealing with statistics means incorporating the variation in the data. On the other side, it means that while a lot of older persons are showing a lot of deficit, there are also a lot of others that are showing relatively little, if any, deficit. That wide span is a very important concept.[9]

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[9] U.S. Congress. Senate. Senate Committee on Aging. Hearing on "How Old Is Old? The Effects of Aging on Learning and Working," Apr. 30, 1980, Washington, D.C. (Senator John Glenn presiding), p. 10.

Reubin Andres, M.D., of the National Institute on Aging, agreed:

> There is no adult plateau period during which no aging decrements occur. Even 30-year-olds cannot perform as well as 20-year-olds in many of the tests that are done. A second truism is that variability in functions in system after system is remarkably large, so that there are some elderly people who perform quite as well as average middle-aged adults on specific tests, and conversely some middle-aged adults who in certain specific ways resemble an average elderly person.[10]

Ironically the four corporate witnesses at the second hearing agreed that a major obstacle to the employment of the older worker is the persistence of the very myths that the scientific research has shown to be false. Harold Page, vice president for personnel of Polaroid, stated bluntly that "our observation is that the story that older workers have poor attendance is purely a myth." As to accidents, Gerald Maguire, vice president of corporate services for Bankers Life & Casualty of Chicago, said that "our compensable time lost is about somewhere between a third and a fifth for the older worker as opposed to the regular worker." It is relevant to again note in this context that neither Polaroid nor Bankers has ever had a policy of mandatory retirement.

Why do such myths persist? One answer is that the phenomenon of the older worker on a large scale is relatively new, and is getting growing attention as the legal barriers to older employment have diminished. Another, perhaps more direct answer was given by C. Peter McColough, chief executive officer of Xerox, and Chairman of the President's Commission on Pension Policy. He said that for many corporate executives there has been a reluctance to look at the entire problem. "It is like a lot of things in our society—until you really focus in on something you don't understand it."

One of the most direct statements of corporate experience refuting the negative stereotypes of the older worker came in the third hearing held in Orlando, Fla., July 9, 1980. George Tschudi, personnel manager of the Grumman Aerospace Corp. facility in Stuart, Fla., described his experience in rehiring his company's own retirees. When asked about the stereotype of the older worker as accident-prone, absence-prone, and unable to benefit from retraining, Mr. Tschudi said that none of those conditions held true in his experience. In fact, Grumman's experience was just the opposite: "Our retired employee who comes back to work has a consistently better attendance record than our regular employees," and "some of these people have done as well or better than some of the people who were younger and being trained for that same task." In sum, Mr. Tschudi agreed it was good "bottom line" corporate management practice for Grumman to retain older employees for a longer time, and to rehire retired employees.

Clearly one of the important conclusions to emerge from these hearings is the need to inform the public, as well as private and public employers more generally, that these negative stereotypes are indeed myths and are supported neither by research evidence nor by the experience of many employers. Yet it is important to note again that this orientation does not suggest that normal retirement, or even early retirement, should be withheld from those workers who so choose it. For those millions of older persons who have expressed either the desire not to retire or a preference for partial retirement combined with part-time employment, it is clear that planning must be initiated to explore the various options.

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[10] Ibid., p. 5.

It is also apparent that such exploration must be started sooner rather than later. As Karl Kunze, chairman of the National Institute on Age, Work, and Retirement of the National Council on the Aging, said in the first hearing, "stereotypes about older people and their capabilities took decades to work themselves into our consciousness and they will not be excised overnight."

The creation of work opportunities, as witnesses pointed out, often requires an innovative examination of the older worker within the work situation. As Dr. Schaie noted, the particular strengths of the older worker can be maximized, and weaknesses minimized, when employers make some effort to match the worker with the job.

That such is possible was described by Jerome Rosow, president of Work in America Institute, Inc., and a former Assistant Secretary of Labor. Mr. Rosow described a study by his institute which surveyed 170 organizations, and which produced case studies of 69 innovative older worker programs in organizations representing over 2.5 million employees. He described six general types of innovative approaches to older worker employment which were identified in organizations including employers in both the public and private sectors. The six types are: Part-time work, phased retirement, second career training, job redesign, reentry workers, and older worker oriented job-finder organizations.

A major outcome of these hearings, then, is the evidence that one of the primary obstacles to the employment of the older worker is a set of negative myths and stereotypes denigrating the older worker's ability to function effectively. As several of the witnesses said, one major response would be a program of education and incentives aimed at employers to encourage the development of options for the older worker.

The general policy response to this set of issues must be located in cooperation between government and employers. New government employment programs, in an era of increasing budget consciousness, are less and less likely or desirable. Therefore, to reverse or slow down recent trends toward early retirement, and to promote and make available options for a longer worklife for older persons, the major thrust is likely to be in some form of partnership between government and private industry. The contours of such a cooperative arrangement will be a continued focus of the committee in future hearings.

In conclusion, the hearings suggest that Congress has a responsibility to follow up on its success in limiting the discriminatory practices of mandatory retirement. Even if all age-based mandatory retirement becomes legally prohibited, the Congress still has the responsibility of encouraging a social and economic environment in which employers hire the older worker. In short, to paraphrase Pension Commission Chairman McColough, encouraging increased work force participation by older persons through more availability of full-time and part-time employment opportunities must become a matter of national policy.

Chapter 3

FEDERAL HEALTH PROGRAMS

CHAPTER HIGHLIGHTS

A continued emphasis on finding ways to control the escalating costs of Federal health programs eclipsed efforts to significantly expand Federal health benefits for the elderly. Some liberalization of medicare benefits was passed by Congress, primarily in home health, but tighter administrative controls were also required.

Committee on Aging hearings entitled "Aging and Mental Health: Overcoming Barriers to Services" resulted in a number of amendments to the Mental Health Systems Act to improve community mental health services to the elderly, although legislation to ease restrictions on medicare coverage for mental health services did not pass Congress.

I. MEDICARE: THE DILEMMA OF RISING COSTS AND INCREASING GAPS

Overall national health spending continues to rise at a rapid rate, with a significant portion paid by medicare. At the same time, older Americans face continued increases in out-of-pocket health care payments. The 96th Congress passed a number of medicare amendments, including significant expansions of medicare reimbursement for home health services, but other medicare reforms strongly supported by the elderly and major aging organizations were dropped during final congressional deliberations in an effort to cut overall program costs.

A. COST OF HEALTH CARE: 1979 AND BEYOND

Total national health expenditures, public and private, for calendar year 1979 reached $212.2 billion, an increase of 12.5 percent over 1978 expenditures.[1] Total national expenditures are projected to be $245 billion in 1980, and at current spending trends, reach $758 billion by 1990.

The largest portion of total expenditures are for hospital care: $85.3 billion in 1979, estimated to be $97 billion in 1980, and projected to reach $335 billion by 1990. Total public expenditures for hospital care in 1979 were $47.7 billion. Medicare's portion of these public expenditures was $21.7 billion, or 25 percent of all personal health care payments made to hospitals.

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[1] The Health Care Financing Administration prepares an analysis of national health expenditures each year. The most current figures available are for calendar year 1979. All expenditures for 1979 cited in this section are from "National Health Expenditures, 1979," Health Care Financing Review, summer 1980. Estimates for 1980 and future years are from "Projections of National Health Expenditures: 1980, 1985, and 1990, "Health Care Financing Review, winter 1980. Office of Research, Demonstrations, and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services.

Payments for physicians' services comprise the second largest category of total public and private national health expenditures: $40.6 billion in 1979, estimated to be $45 billion in 1980, and projected to reach $129 billion in 1990. Public expenditures for physicians' services in 1979 were $10.6 billion, with medicare accounting for $6.4 billion, or 16 percent of all health care payments made to physicians.

Nursing home services continue to be the fastest growing category of total national health expenditures: $17.8 billion in 1979, estimated to be $22 billion in 1980, and projected to reach $76 billion in 1990. Public expenditures for nursing home care in 1979 were $10.1 billion. Medicare payments accounted for only $373 million of this total, with the bulk of public payments coming from medicaid. Total Federal and State medicaid payments to nursing homes in 1979 were $8.8 billion. The Federal medicaid share was $4.8 billion.

B. The Medicare "Payment Gap"

The Committee on Aging's annual report for 1979, in a section entitled "The Individual View: Frustration With Medicare," summarized a number of widely perceived problems with the medicare program as viewed by medicare beneficiaries.[2] Witnesses at a committee hearing on "Federal Paperwork Burdens, With Emphasis on Medicare" cited the following problems: Dissatisfaction with the amount of medicare benefit payments, including very high rates of reduction on claims filed; broad confusion over program benefits; increasingly low medicare "assignment" rates; and frustration with handling of claims by medicare part B carriers, including lengthy delays in payment, difficulties in obtaining information, and a cumbersome appeals process.

A recent report published by the House Select Committee on Aging cited the same problems, along with continued gaps in medicare coverage for important health services—such as home care, nursing home care, prescription drugs, and preventive health services—and questioned whether medicare was viewed by many elderly as a "broken promise."[3] The General Accounting Office (GAO) also submitted a report to the Senate Committee on Aging during the year detailing a number of areas in which the Comptroller General felt elderly medicare beneficiaries were being subjected to inequitable reductions in their medicare claims.[4]

Medicare's share of all personal health expenditures for the elderly is about 40 percent, including payments for hospital stays and physician services. Much of the attention, and the complaints, have been focused on medicare payments for physician services (part B)—where medicare payments for covered services represent only 31 percent of all physician charges to medicare beneficiaries.[5] The major reasons for this declining percentage of medicare payments for physician services under the medicare part B program are discussed below.

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[2] "Developments in Aging: 1979," part 1, pp. 55–59.

[3] U.S. Congress. House of Representatives. Select Committee on Aging. "Medicare After 15 Years: Has It Become a Broken Promise to the Elderly?" (Washington, Nov. 17, 1980).

[4] U.S. General Accounting Office. "Reasonable Charge Reductions Under Part B of Medicare"; Report to the Senate Committee on Aging and the Secretary of the Department of Health and Human Services by the Comptroller General of the United States. Washington, 1980 (HRD-81-12, Oct. 22, 1980).

1. PREMIUM, COINSURANCE AND DEDUCTIBLE INCREASES

By law, the medicare coinsurance and deductible amounts which beneficiaries must pay are increased each year. Under the part A program (hospital insurance), the amounts each medicare beneficiary must pay out-of-pocket increased by 13.3 percent on January 1, 1981. The initial deductible for part A hospital insurance was increased to $204, $24 more than the 1980 charge of $180. Daily coinsurance charges for long-term hospital stays and skilled nursing facility stays also increased by 13.3 percent.

On July 1, 1981, the basic monthly premium paid by medicare beneficiaries for medicare supplementary health insurance (part B) will increase by 14.5 percent, from the current $9.60 to $11. Beneficiaries must also pay a $60 deductible each calendar year, and a coinsurance charge of 20 percent of the allowed charge for all covered services. In 1975, the total beneficiary liability for premiums, deductibles, and coinsurance charges was about $3.2 billion.[6]

2. DECLINING ASSIGNMENT RATES AND HIGH "REASONABLE CHARGE" REDUCTIONS

Under part B of the medicare program, physicians can either "accept assignment"—billing medicare directly for services provided and agreeing to charge the beneficiary no more than medicare pays—or bill the medicare beneficiary directly who then files a claim for reimbursement. When the medicare beneficiary is billed, the amount submitted is frequently in excess of what medicare allows and the difference must be paid out-of-pocket by the beneficiary.

This difference between submitted and allowed charges on unassigned claims, and the overall proportion of medicare claims which are submitted on an unassigned basis, has been increasing steadily since medicare's inception.

The percentage of unassigned claims has increased to about 50 percent from about 35 percent in the early years of medicare (1969 rate). Assignment rates are lower for the aged than for disabled medicare beneficiaries (47 percent of all physicians' charges for the aged and 62 percent of all physicians' charges for the disabled) and vary considerably by area of the country, from a low of 20 percent in South Dakota to a high of 82 percent in Rhode Island.[7]

During fiscal year 1979, medicare beneficiaries had to pay over $1.1 billion for the difference between submitted and allowed charges on these unassigned claims. This beneficiary liability was $882 million in fiscal year 1978, compared to $433 million in 1975, and $50 million in 1968.[8]

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[5] U.S. Department of Health and Human Services. Health Care Financing Administration. "Physician's Charges Under Medicare: Assignment Rates and Beneficiary Liability," Health Care Financing Review, winter 1980.

[6] Ibid.

[7] Ibid.

[8] Ibid.

These amounts represent the overall difference between what medicare considers "reasonable" charges and what physicians charge medicare beneficiaries for their services. In 1979, 81 percent of all unassigned claims submitted for payment by medicare beneficiaries were subject to a reasonable charge reduction. In 1975, 69 percent of all claims were reduced.

GAO Cites "Inequitable" Reductions

Early in 1980, the Committee on Aging requested a General Accounting Office (GAO) audit of a sample of unassigned claims processed by medicare carriers (private insurance companies under contract with the Federal Government to process and pay medicare claims) to determine whether or not beneficiaries were being reimbursed properly. In an October 1980 report to the committee, the GAO cited physician markups on laboratory work, medicare reimbursement policies on dual surgical procedures, and inadequate review of claims by carriers as three areas in which it believed beneficiaries were being subjected to inequitable reasonable charge reductions.[9]

Excessive physician markups on laboratory procedures performed by independent laboratories: 93 percent of all unassigned claims for laboratory work processed by Group Health, Inc., Miami, Fla., were marked up by an average of 105 percent. Unassigned laboratory claims processed through Florida Blue Cross had a net markup of 95 percent. Claims processed through Group Medical and Surgical Service in Texas showed a net markup of 89 percent, and those processed through Travelers Insurance Co., Mississippi, showed a net markup of 54 percent.

A physician can have laboratory work performed either in his or her own office, or send the work out to an independent laboratory, which in turn bills the physician for the work performed. The physician then adds this amount to the bill submitted directly to medicare or to the patient. These additional amounts, the markups, will not be paid by medicare (except for the physician's costs for paperwork and handling). The excess charge, an average of $13 per claim for one carrier, is added to the medicare beneficiary's out-of-pocket costs for laboratory tests.

If these findings from the GAO audit are routine practice across the country, and it appears that they are, the committee estimates that this practice adds $20 million a year to beneficiary out-of-pocket costs.

Noting that the American Medical Association (AMA) has stated that physician markups are unethical, GAO recommends making it a misdemeanor for physicians to add charges to laboratory bills. Alternatively, GAO recommends requiring laboratories to charge medicare directly, thereby removing physicians entirely from the billing process.

Public Law 96-499 (Omnibus Reconciliation Act of 1980) contains an amendment designed to make it easier for medicare carriers to accurately determine whether or not a claim submitted for laboratory services includes a markup, so that the amount billed can be appropriately reduced. No protections against the medicare beneficiary being subject to the overcharge however, were included in the new law.

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[9] U.S. General Accounting Office, "Reasonable Charge Reductions Under Part B of Medicare," op. cit.

Use of "fee-and-one-half" reimbursement policies for dual surgical procedures: GAO found that physicians routinely charge two full fees for two surgical procedures performed during a single operation, while medicare and many private health insurance payment practices usually limit the amount reimbursed to the full fee for the major procedure and partial amounts for other procedures performed during the operation. (The equivalent, in most cases, is a "fee and one-half"). The medicare beneficiary is required to pay the difference out-of-pocket to the surgeon. Based on the GAO's calculation of the cost to beneficiaries in the Washington, D.C., area, the committee estimates that this practice results in additional out-of-pocket cost to beneficiaries nationwide of at least $50 million each year.

Inadequate scrutiny of claims as they are processed by medicare carriers: In a review of claims paid by the District of Columbia carrier which showed reasonable charge reductions of $150 or more, the GAO found 42 percent of the claims had been incorrectly processed and the medicare beneficiary underpaid. The GAO recommended that more specific claims processing standards be established to provide assurances that beneficiaries are not underpaid.

This GAO audit finding that 42 percent of claims processed have errors resulting in incorrect payments to beneficiaries suggests that thousands of beneficiaries could realize higher reimbursements on part B claims if they questioned large reductions. The process of appealing carrier decisions, however, is not often used. Only about 2 to 3 percent of beneficiaries ever request a review, but half of those who do, receive increased reimbursement.

There are indications that the frustration of increasing out-of-pocket costs for all physician services, added to growing beneficiary sophistication about program procedures and avenues of recourse, will lead to a higher and higher volume of requests for review of claim determinations.

A hint of what this increased workload may mean for medicare carriers, and for the part B payment system itself as the program increases in complexity, may be seen by the case of EDSFC.

3. INADEQUATE CLAIMS REVIEW: THE RESULTS

Early in 1980, a rash of complaints from Illinois medicare beneficiaries about long delays in processing medicare part B claims and unanswered inquiries by the carrier (Electronic Data Systems Federal Corporation (EDSFC)) led to hearings by the Subcommittee on Health of the House Committee on Ways and Means.[10] EDSFC, which had been awarded an experimental medicare claims processing contract for the entire State in April 1979, was the lowest bidder for the contract. It did not have broad technical expertise or experience with the medicare program. By September 1979, official records showed 454,000 claims backlogged and pending. In March 1980, records indicated 110,000 additional backlogged items of correspondence from beneficiaries. Under pressure to meet contract standards, changes were made, extra staff hired, and claims and correspondence backlogs appeared to be reduced. However, a later GAO investigation found that this pressure had led to some extraordinary measures, most of which escaped detection by contract monitors from the Health Care Financing Administration (HCFA).[11]

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[10] U.S. House of Representatives. Committee on Ways and Means. "Experimental Medicare Claims Processing Contract," field hearing, Subcommittee on Health, Chicago, Ill., Apr. 28, 1980. Congress has granted the Health Care Financing Administration authority to experiment with competitive fixed-price procurement for medicare claims processing contracts. Three contracts have been awarded in Illinois, Maine, and New York, on a demonstration basis. The GAO is now evaluating all three contracts, with a report to the Subcommittee on Health, House Committee on Ways and Means, scheduled during 1981.

The GAO found that:

—EDSFC employees concealed unprocessed claims from an end-of-the-year review so they would not be counted as backlog by HCFA investigators.

—Thousands of letters from claimants were destroyed without response, to remove them from the backlog. A GAO sample found 44 percent of these letters were requesting reviews or submitting additional information for claims.

—Additional thousands of items of correspondence which had been partially reviewed at another location were destroyed rather than completed once they were returned to the main office. GAO found that 90 percent of a similar sample of mail in question was either a request for review or a claim. HCFA monitoring does not include any tests to determine if correspondence is answered.

—EDSFC employees allowed claims with known errors in them to be processed. HCFA performance standards requiring documentation of any such irregularities in processing were not enforced.

—Thousands of "Explanation of Medicare Benefits" forms which were returned by the post office as "undeliverable mail" were destroyed without any attempt to determine why they were incorrectly addressed. HCFA standards require such returns be analyzed to determine reasons for return, remail them, and pursue possible fraud and abuse problems. Based on a later sample, the GAO determined the returned mail which had been discarded contained other items, including correspondence and undelivered checks.

The GAO also found that of nine fair hearing officers employed by EDSFC, none were attorneys and only three had any college degree (in completely unrelated areas; home economics, journalism, and public administration). HCFA standards provide for "an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology" and with thorough knowledge of the medicare program. Most fair hearing officers across the country are attorneys. HCFA had not evaluated the hearing officers' qualifications.[12]

The GAO strongly recommended an increased level of onsite contract monitoring and continual oversight of handling of reviews.

Many of these problems might have been avoided if the carrier had been more experienced with the medicare program, but similar allegations were recently made of a much more experienced carrier.

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[11] U.S. General Accounting Office. "Review of Alleged Questionable Actions by EDSF To Reduce Its Claims and Correspondence Backlogs Under Its Medicare Contract" (Report No. HRD–81–44, Dec. 16, 1980).

[12] On May 16, 1980, the U.S. District Court for the Northern District of California decided, in a nationwide class action, that medicare part B hearings presided over by employees of the private insurance companies that act as medicare carriers, whose decisions are final and cannot be appealed, violate the U.S. Constitution (*McClure* v. *Harris*, No. C–79–0201–WHO).

In December 1980, the Washington Star reported allegations by employees of the District of Columbia Blue Shield that, during 1978 and 1979, officials had withheld from 10 to 20 percent of all medicare claims—those with known high rates of error—from sample batches which were to be inspected by Federal officials as part of a quality assurance review. According to employees, the actions were taken at a time when the error rates of the carrier were high enough to threaten their contract agreement with HCFA.

C. The 1980 Medicare Amendments

The 96th Congress took final action on a number of amendments to both expand medicare coverage and cut back on program costs which are discussed below in section II. Some amendments of particular importance to the elderly, however, did not finally emerge from the 96th Congress. A summary of the most significant of these actions is discussed below.[13]

1. BENEFIT EXPANSIONS SIGNED INTO LAW

Expanded medicare coverage for home health services: A number of amendments which will significantly expand medicare coverage for home health services were signed into law on December 5, 1980 (Public Law 96–499).[14]

New medicare coverage for pneumococcal vaccine: An amendment to the medicare program to provide full reimbursement for pneumococcal vaccine was signed into law on December 28, 1980 (Public Law 96–611). The new coverage will be effective on July 1, 1981, and reimbursement will be available without copayment or deductible.

This change in medicare law represents an exception to the current exclusion of coverage for preventive immunizations and other preventive health services. (The medicare statute is directed toward treatment or diagnosis of specific illness or injury and therefore excludes payment for routine physical checkups, immunizations, health screening, etc., without specific statutory exception.)

Additional amendments: The following amendments, which become law during 1980 (Public Law 96–499) expand medicare coverage in certain specific areas:

- —The annual medicare reimbursement ceiling for outpatient therapy services furnished by independently practicing therapists was increased from $100 to $500.
- —Medicare payment is authorized for currently covered services which are provided by freestanding outpatient rehabilitation facilities. Present law recognizes coverage for a variety of rehabilitation services, such as physical, speech, and occupational therapy, as provided by qualified providers and incidental to other physicians' services. Comprehensive rehabilitation centers had not been recognized as providers prior to this change in the law.

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[13] Significant changes in medicare reimbursement for home health and nursing home care are discussed in chapter 4, long-term care. In addition to amendments discussed here, many additional amendments passed were primarily of an administrative nature, and a full report can be found in U.S. House of Representatives, Report No. 96–1479, Omnibus Reconciliation Act of 1980, conference report, Nov. 26, 1980.

[14] See following chapter 4, long-term care, for full description of these amendments and other activities in home health during 1980.

—Medicare payment is now authorized to dentists who perform certain dental procedures which would otherwise be covered if performed by a physician. Prior to this change in the law, only certain surgical procedures related to the jaw were covered when performed by dentists. The change will allow payment to dentists for other already covered services, such as treatment of oral infections. No change is made, however, in the general exclusion from coverage of routine dental care.

—Medicare payment is authorized for treatment of warts on the feet (plantar warts). Previously, treatment for warts was covered only if they occurred on other parts of the body. The general exclusion of routine foot care from medicare coverage, however, continues to apply.

—Medicare payment is now authorized to optometrists for examination services in relation to aphakia—a condition of the eye in which the natural lens is absent. Prior to this change in the law, these same services were covered only when performed by a physician.

2. DECISIONS DEFERRED ON MENTAL HEALTH AND HMO'S

Even though legislation to expand medicare coverage for mental health services had passed the House of Representatives in 1978 (H.R. 3990), this legislation was deleted from the final package of amendments emerging from the 96th Congress and did not become law.[15]

During each of the last two Congresses, legislation has been considered to broaden the use of medicare payments to encourage more elderly participation in qualified health maintenance organizations.[16] The full House passed, on September 4, 1980, this provision as part of H.R. 7765, the Omnibus Reconciliation Act of 1980, but it was later dropped during a conference with the Senate.

This proposal has gathered increased support among Members of the Senate and is strongly endorsed by both the National Retired Teachers Association/American Association of Retired Persons and the National Council of Senior Citizens. It is expected that a similar measure will be reintroduced early in the 97th Congress.

II. CONTINUED EMPHASIS ON CONTROLS FOR MEDICARE-MEDICAID ABUSE

The effectiveness of State medicaid antifraud units received a favorable evaluation in 1980 and Federal funding was extended to allow additional time for the establishment of new units. Many States were also required to improve their management of the medicaid program, with a 1982 deadline set for all States to have medicaid management information systems in place. Additional amendments to the Social Security Act were passed by Congress to improve administrative controls over the medicare and medicaid programs, for which combined expenditures were about $52 billion in 1979. Special attention was given to the medicare home health program with a number of administrative changes made to tighten program controls.

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[15] See following section on mental health for full description of this legislation and other mental health legislation which was approved during the year.

[16] In 1978, S. 2676 and H.R. 11461 were proposed by the administration. The House bill received 1 day of hearings by the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. In 1979, S. 1530 and H.R. 4444 were proposed by the administration. Hearings were held by the House Committees on Interstate and Foreign Commerce and Ways and Means and the amendments were reported to the floor as part of H.R. 4000 and H.R. 7765. The Senate bill was cosponsored by Committee on Aging members Heinz, Bradley, Chiles, Church, Cohen, and Glenn. See "Developments in Aging: 1979," part 1, pp. 66–69, for a full discussion of the proposal as well as Committee on Aging hearings conducted by Senator Heinz.

A. STATE MEDICAID FRAUD CONTROL UNITS

The 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142) authorized 90-percent Federal medicaid funding for a period of 3 years (1978–80) as an incentive for States to establish special medicaid fraud control offices. The 90-percent Federal matching rate was intended to allow each State a full 3-year period to establish a unit, after which time the Federal share of funding would revert to the 50-percent Federal share paid for most medicaid administrative activities. By September 30, 1980, when the authorization period for the 90-percent Federal rate was to end, 30 States had organized fraud control offices. About two-thirds of the units, however, had not established themselves early enough to have the benefit of a full 3 years of 90-percent Federal funding and it was doubtful that they would be able to continue operations without an extension of their authorization.

A General Accounting Office (GAO) evaluation[17] of already established units concluded that the units could be effective in combating medicaid fraud and that their effectiveness should increase as more experience was gained. The units had increased States' ability to investigate and prosecute medicaid fraud with increases in the number of staff, cases handled, and convictions. The GAO felt that the antifraud units acted as a deterrent to attempted fraud by medicaid providers and had an impact on changing State legislation and medicaid regulations to make it easier to identify fraud and provide for more stringent penalties.

The GAO also agreed that it would be extremely difficult for the units to become self-supporting if the expanded Federal matching fund period was ended.

FEDERAL FUNDING EXTENDED

Legislation to extend the period of 90-percent Federal match funding for the State units was favorably reported by the Senate Finance Committee in 1979 (H.R. 934, December 10, 1979) and by the House Committee on Interstate and Foreign Commerce early in 1980 (H.R. 4000, April 23, 1980); however, final action still had not been taken on these bills as the end of the period for increased Federal funding drew near.[18]

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[17] U.S. General Accounting Office. "Federal Funding for State Medicaid Fraud Control Units Still Needed," report to the Congress by the Comptroller General of the United States. Washington, 1980, (HRD–18–2, Oct. 6, 1980).

[18] See U.S. Congress. Senate. Special Committee on Aging. "Developments in Aging: 1978," part 1, pp. 70–72, and "Developments in Aging: 1979," part 1, pp. 96–97, for earlier reports of hearings conducted by the Committee on Aging in July 1978 on the effectiveness of the State medicaid fraud control units and the progress of legislation to extend Federal funding for the units in 1979.

Concerned that a number of the State units would go out of existence before they had been given adequate time to establish themselves, Senators David Pryor and Frank Church of the Special Committee on Aging won Senate approval of an amendment to the Health Sciences Promotion Act of 1980 to continue authorization for 90-percent Federal funding until October 1, 1982.[19] It soon became apparent that this bill would not be passed by the full Congress and signed into law before the end of the fiscal year when authorization for the fraud units would expire. In response, Senator Lawton Chiles, chairman of the Special Committee on Aging, amended a continuing appropriations resolution to continue funding for the units.[20] The amendment provided for 90-percent Federal funding of State fraud control units until December 19, 1980.

During this period, Congress completed action on the Omnibus Reconciliation Act of 1980, signed into law on December 5, 1980 (Public Law 96–499), which authorizes Federal matching payments to any State for the costs of establishing and operating State medicaid antifraud units at a rate of 90 percent for a 3-year period and 75 percent thereafter.

At least 11 additional States are expected to establish medicaid fraud control units as a result of this action, and continued operation of the 30 existing units is guaranteed.

B. STATE MEDICAID MANAGEMENT SYSTEMS

Section 901 of Public Law 96–398, signed October 7, 1980, contains an amendment sponsored by Senator Richard Schweiker which requires that all State medicaid programs must have mechanized claims processing and information retrieval systems (medicaid management information systems—MMIS) in place by September 30, 1982, in order to avoid penalties in Federal medicaid reimbursement for administrative expenses. The new law also requires the Secretary of the Department of Health and Human Services to provide to States technical assistance for system operation. Information relating to the detection of fraud and abuse in the medicaid program must be exchanged and shared with medicare program administrators.

As of October 7, 1980, 32 States and New York City had approved MMIS systems in place.

C. NEW ABUSE AMENDMENTS

The Omnibus Reconciliation Act of 1980 (Public Law 96–499) provided for further controls against abuse in the medicare and medicaid programs. The Federal Government was given access to records of those who contract with medicare providers to supply services as well as the authority to recover overpayments to medicare providers and to bar convicted abusers from any further participation in medicare or medicaid or the title XX program of social services.

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[19] S. 988, Public Law 96–538, signed Dec. 17, 1980. See Pryor, David. Remarks in the Senate. Congressional Record, June 19, 1980: p. S7504 and Church, Frank. Remarks in the Senate. Congressional Record, June 20, 1980: p. S7631.

[20] Amendment No. 14 to H.J. Res. 610, Public Law 96–369, Oct. 1, 1980.

1. ACCESS TO CONTRACTOR RECORDS

Federal reimbursement through medicare to providers of covered services (such as home health agencies, skilled nursing facilities, hospitals, etc.) for the costs of services furnished by subcontractors will no longer be allowed unless the Secretary or the Comptroller General is given full access to the records of the subcontractor. All contracts negotiated by medicare providers must stipulate access to records for 4 years after the services are furnished. The new law applies to all contracts whose cost or value is $10,000 per year or more. The same access to records must also be provided for any further contract between a subcontractor and any other organization related to the subcontractor by common ownership or control.

Testimony taken by Senator Lawton Chiles before a Senate Special Committee on Aging hearing in late 1979 demonstrated the difficulties experienced by Federal auditors in obtaining access to the books and records of contractors.[21] Medicare funds were reimbursing for the services of management companies contracting with home health agencies for startup and continuing administrative services. Medicare auditors, however, who have the responsibility to verify a home health agency's administrative costs, had no access to the management company's cost records. Unless voluntarily given, auditors had to go through a lengthy process of administrative subpena by the Department of Health and Human Services or a grand jury subpena through the Justice Department.

An earlier General Accounting Office (GAO) report questioned the costs of a number of long-term contracts to home health agencies for administrative and consulting services.[22] GAO auditors found instances in which contracts were negotiated for 20 to 30 years. They also questioned the use of franchising arrangements in home health agency contracts, in which the home health agency agreed to pay the contractor for administrative services based on a percentage of medicare reimbursements received from the Federal Government.

Subsequent to the GAO report and the hearings before the Committee on Aging, Representative Sam Gibbons, chairman of the House Ways and Means Subcommittee on Oversight, proposed an amendment to H.R. 3990 to apply limitations on medicare reimbursement for contract services.[23] The amendment was limited to home health agency contracts and prohibited reimbursement for the costs of any contract which exceeded a term of 5 years or for which payment was based on a percentage of medicare reimbursement. It was later modified to apply to contract arrangements by all types of medicare providers.

2. EXCLUSION FROM PROGRAM PARTICIPATION

Any health professional who has been convicted of any program-related crime under medicare or medicaid will be barred from further participation in these programs as well as the title XX social services program. (Examples of program-related crimes would be accepting a kickback or bribe from a supplier of services, or submitting a falsified cost report to the Federal or State government.)

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[21] U.S. Congress. Senate. Special Committee on Aging. "Abuse of the Medicare Home Health Program." Miami, Fla., Aug. 29, 1979, p. 12. See "Developments in Aging: 1979," part 1, pp. 94–96, for report on additional hearing findings.

[22] U.S. General Accounting Office. "Home Health Care Services—Tighter Fiscal Controls Needed," report to the Congress by the Comptroller General of the United States. Washington, 1979. (HRD–79–17, May 15, 1979).

[23] Reported to the full House by the Ways and Means Committee on Nov. 5, 1979 (H. Rept. No. 96–588, part 1) and by the House Committee on Interstate and Foreign Commerce on Mar. 18, 1980 (H. Rept. No. 96–588, part 3).

Exclusions from participation under previous law did not include the title XX program and were applicable only to physicians and other practitioners. Under the new law, any health professional receiving reimbursement from medicare or medicaid, such as an administrator of a nursing home, hospital, or home health agency, who has been convicted of a crime related to either the medicare or medicaid program will no longer be able to receive any payment for services from medicare, medicaid, or title XX.

3. RECOVERY OF MEDICARE OVERPAYMENTS

The Secretary of the Department of Health and Human Services is authorized to withhold the Federal share of medicaid payments due a provider of services to recover any medicare overpayments made to that provider.

Medicare providers are paid on the basis of the costs incurred by the provider for services rendered to medicare beneficiaries, including the administrative costs of operating the nursing home, home health agency, hospital, or other type of medicare-certified agency. In the case of a facility which also receives reimbursement from other sources, medicare pays a proportionate share of the administrative costs. Medicare payments are made to the facility on the basis of a report of costs incurred during a particular time period, usually 1 year. Frequently, an estimate of the costs which will be incurred during a coming year is used to make periodic "advance" payments to the facility.

Once the end-of-the-year cost report is submitted to the medicare program, it is audited to verify that the costs claimed by the facility are allowable charges under the medicare program and that they are "reasonable" amounts for the costs of doing business and providing services. Any differences in reimbursement between the amounts paid to the provider during the year and the results of the audited cost report are then settled with the provider. Additional medicare payments can be made to the provider—or the provider can be required to repay any overpayments to the medicare program. If the provider continues to participate in medicare, overpayments can be withheld gradually from future medicare reimbursements.

In some cases, medicare providers have been able to submit inflated cost estimates during a period of providing services, and then withdraw from the medicare program—or reduce their level of participation enough so that the recovery of overpayments would not be possible. Prior to this change in the law, the Secretary could only withhold the Federal share of medicaid payments if the provider was no longer participating in the medicare program. The change allows the Secretary to extend this use of medicaid withholding under circumstances in which the provider continues to participate in medicare, but at a level too low to cover prior overpayments. It also would apply, for example, to a situation in which a physician initially accepting medicare assignment (agreeing to accept medicare as payment in full for services provided to medicare beneficiaries) ultimately refuses assignment.

The amendments to recover medicare overpayments and to bar convicted abusers from further program participation were introduced in the Senate by Senators Lawton Chiles, John Melcher, and David Pryor of the Committee on Aging in August 1979 (S. 1662).[24] The amendments were favorably reported by the House Ways and Means Committee on November 5, 1979, and were subsequently accepted by Senate conferees as part of the Omnibus Reconciliation Act of 1980. S. 1662, a measure to authorize the Secretary of the Department of Health and Human Services to impose civil monetary penalties for fraudulent claims for medicare or medicaid, was not acted upon.

D. MEDICARE HOME HEALTH CONTROLS

Medicare's home health program is of primary importance for thousands of home-bound elderly suffering from illness and disability. The utilization of home health services has been increasing dramatically in recent years (see following box). Part of the reason for this increase is the rising proportion of older persons in the population, and part is due to a heightened awareness of the desirability of home health services on the part of physicians and other health care professionals selecting the appropriate modes of health care for their patients. A third reason is the increasing number of medicare-certified home health agencies, making services more widely available.

The Federal Government has taken an active role in increasing the number of medicare-certified home health agencies through a program of small grants for startup and development of agencies in underserved areas of the country, as well as training of home health agency personnel. This program, which is discussed more fully in chapter 4, has been responsible for the development of 344 medicare-certified home health agencies, primarily in rural areas of the country, during its 5 years of existence.

This year, Congress amended the medicare law to remove a requirement that proprietary home health agencies be licensed by a State as a condition for participation in medicare.[25] In mid-1980, only 25 States licensed proprietary home health agencies, and proprietary agencies only accounted for about 6 percent of all medicare-certified agencies. This change in law, however, will contribute to an even more rapid growth in the number of agencies participating in the medicare program.

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[24] "Medicare and Medicaid Fraud and Abuse Amendments of 1979," introduced in the Senate Aug. 2, 1979. See Chiles, Lawton. Remarks in the Senate. Congressional Record, Aug. 2, 1979; p. S11493.

[25] As part of Public Law 96-499, signed Dec. 5, 1980.

GROWTH OF THE MEDICARE HOME HEALTH PROGRAM

Total medicare reimbursement for home health services increased from $217 million in 1975 to $912 million in 1981.

Almost 16 million medicare-reimbursed home health visits were made to the elderly and disabled in 1977. Aged medicare beneficiaries account for over 90 percent of both the number of home health visits made and the medicare reimbursements to home health agencies.

The number of medicare-certified home health agencies has increased from about 2,250 in 1975 to about 3,000 in 1980.

Source: Office of Research, Demonstrations, and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services.

Until recently, very little attention has been paid to the development of this health industry within the medicare program. One reason is because home health expenditures represent so small a proportion of total medicare spending—under 2 percent. The recent growth of the home health program under medicare, however, has led to an increased focus on abuses within the program.[26] A number of amendments considered in the Senate and House in 1979 were enacted into law this year.[27]

1. BONDING AND ESCROW ACCOUNTS

The Secretary of the Department of Health and Human Services was given the authority to establish bonding and escrow requirements for home health agencies having little or no funds other than those received through medicare payments.

The Secretary could take this action in order to assure that a source of funds would be available to make repayment of medicare overpayments. Medicare would no longer reimburse home health agencies for interest on funds borrowed to repay medicare overpayments.

The amendment was in response to concerns about the rising numbers of "medicare-only" or "100-percenter" home health agencies for which medicare pays most or all administrative expenses as well as service costs. About 570 home health agencies now operate with at least 80 percent of all their funds coming from medicare. Over half of these, 335, operate with 90-percent medicare funding.

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[26] U.S. Congress. Senate. Special Committee on Aging: "Abuse of the Medicare Home Health Program," 1979. "Developments in Aging: 1979," part 1, pp. 94–96.

[27] Amendments attached to H.R. 3990 by Representative Sam Gibbons. Reported in the House by the Committees on Ways and Means and Interstate and Foreign Commerce. Enacted into law as part of H.R. 7765, Omnibus Reconciliation Act of 1980, Public Law 96–499, signed Dec. 5, 1980.

2. REGIONAL INTERMEDIARIES

The Secretary of the Department of Health and Human Services is required to establish regional intermediaries for home health agencies. This requirement, which will concentrate administration of the medicare home health benefit in a smaller number of intermediaries (private insurance companies processing and paying home health claims), is expected to lead to the development of more expertise in administering the home health program and more reliable cost and utilization information.[28] The development of viable administrative and service cost limits and performance standards for home health agencies has not been entirely successful in the past.

The Department has been working throughout the year to develop a proposal to implement this new requirement. A plan for designation of statewide intermediaries for home health agencies may be proposed early in 1981.

Changes in the medicare law regarding access to contractor records, exclusion from program participation, and recovery of medicare overpayments, discussed above, would also apply to home health agencies.

3. COST CAPS QUESTIONED

An amendment to impose a medicare cost cap on home health agency skilled nursing visits and home health aide visits, which would be no higher than an individual State's daily medicaid payment rate for skilled nursing facility services, was also considered by Congress. This proposal, as well as a proposal to limit the allowable costs for home health agency visits under medicare to the 75th percentile of audited costs, was recommended by the Senate Finance Committee as a way to reduce the overall costs of the medicare program. The amendments were rejected by conferees, however, in the final bill.[29]

The Secretary of the Department of Health and Human Services now has authority to set cost caps on home health agency per visit costs, and caps equivalent to the 80th percentile of unaudited costs are now in effect. They are adjusted upward each year to allow for inflation. The Senate Finance Committee, however, expressed concern over what it termed the "unrealistically high levels" of some home health agency per visit costs, and this concern is likely to continue.

The current average per visit cost cap in effect for freestanding home health agencies is $42.67 for a skilled nursing visit in a metropolitan area (SMSA) and $44.75 in a rural area. Average caps for home health aide visits are $32.36 in an SMSA and $31.49 in a rural area.[30] These caps are in effect for the year beginning July 1, 1980. Limits are also calculated for physical and occupational therapy visits and speech pathology and medical social services. Limits for provider-based home health agencies are calculated differently than for freestanding and are somewhat higher, e.g., $54.17 for a skilled nursing visit and $47.36 for a home health aide visit. The national average daily medicaid skilled nursing facility rate during 1980 was $36.25. Medicaid skilled nursing facility rates vary widely from State to State, as services provided are not always the same. They range from about $16 per day to $55 per day.[31]

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[28] U.S. Congress. Conference Committee on Omnibus Reconciliation Act of 1980. Conference report to accompany H.R. 7765. Nov. 26, 1980. (Washington, 1980. Report No. 96–1479). See also Chiles, Lawton. Remarks in the Senate on introduction of S. 489. Congressional Record, Mar. 1, 1979 : p. S2002.

[29] U.S. Congress. Senate. Committee on Finance. "Spending Reductions: Recommendations of the Committee on Finance Required by the Reconciliation Process, the First Budget Resolution for Fiscal Year 1981." (Committee print, CP 96–36, June 25, 1980) Washington, U.S. Government Printing Office, 1980, pp. 45–47.

III. MENTAL HEALTH

A. Special Committee on Aging Hearings

1980 hearings by the Special Committee on Aging, entitled "Aging and Mental Health: Overcoming Barriers to Service," highlighted both the unmet mental health needs of older Americans and positive solutions to the problem.

In his opening statement at the hearing in Little Rock, Ark., on April 4, 1980, Senator David Pryor, who chaired the "Aging and Mental Health" hearings summed up the magnitude of the problem:

> Twenty-five percent of all reported suicides are committed by individuals age 60 and older, with the highest suicide rates being among men over 85.
>
> The incidence of depression, which is the most common mental illness for all ages, rises sharply for the over-65 population.
>
> Psychosis is the most severe form of mental disorder, and it is twice as prevalent in the over-75 age group as among persons age 25–34.
>
> . . . the National Institute on Aging states that 10 to 15 percent of the cases of organic brain syndrome, or senility, are reversible, with 30 percent of the cases being treatable. Yet 50 percent of the elderly in nursing homes are there because of a diagnosis of senility, and over 3 million Americans are suffering mild to severe symptoms of the condition.
>
> As alarming as these statistics may be, it is more distressing today to compare these needs with the percent of Federal dollars being allocated to mental health research and services for older Americans. Listen to this:
>
> Less than 2 percent of all medicare reimbursement is being spent on mental health care.
>
> Approximately 4 percent of the budget of the National Institute of Mental Health is being devoted to research, training, and services specifically for older Americans.
>
> Nationwide, only about 4 percent of the clients being served by community mental health centers are 65 and older, with approximately half that number receiving ongoing treatment or counseling.

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[30] Federal Register, vol. 45 No. 110, Thursday, June 5, 1980, p. 38014.

[31] Unpublished data prepared for Senate Committee on Aging by Health Care Financing Administration.

> Studies have shown that even those older persons who are being served by community mental health centers received a biased range of services, for example, less individual therapy, more inpatient treatment than outpatient services, etc.
>
> Less than 2 percent of the patients of private psychiatrists are 65 and older, and less than 7 percent of the patients of private practicing psychologists are elderly. In fact, 85 percent of the psychiatric care of older Americans is delivered in institutions.
>
> Specialized training of professionals on the mental health needs of the elderly is insufficient today. For example, less than 100 of the 23,000 practicing psychologists in 1978 had formal training in geriatrics, and only about 400 of them were seeing older clients.

Testimony at the "Aging and Mental Health" hearings reinforced these estimations of the problem, and also supported findings of the President's Commission on Mental Health (published 1978) and the National Conference on Mental Health and the Elderly, sponsored by the House Select Committee on Aging (1979).[32]

The reasons for the failure of the current mental health system to adequately serve the elderly include the following:

- —The stigma many older persons attach to seeking mental health services.
- —Inadequate reimbursement for mental health services under medicare, medicaid, and other health insurance programs.
- —Diagnostic failure due to a lack of differentiation between the physical and mental problems of the older patient, which is complicated by the interaction of prescription drugs the individual may be taking for chronic conditions.
- —Lack of training of physical and mental health professionals in geriatrics and the special mental health problems and needs of older Americans; and
- —Conscious or unconscious discrimination by mental health professionals against the elderly.

The "Aging and Mental Health" hearings focused on how these barriers to mental health care for America's aged population might be overcome. The April 4 hearing in Little Rock brought together representatives of the mental health professions, the State offices of aging and mental health, the Veterans' Administration, local community mental health centers and area agencies on aging. The witnesses explored cooperative efforts among their organizations in Arkansas that have resulted in the State having a better record for serving the elderly than the national average. The key to providing needed mental health services to older persons, according to the witnesses, lies in coordination of physical, mental health, and social services at the State and local levels, outreach to older persons in nonstigmatized settings, differential diagnosis to identify the physical and mental problems facing the elderly patient, and adequate training of personnel in both aging and mental health.

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[32] For a further discussion of these findings, see "Developments in Aging: 1978," part 1, pp. 58–60, and "Developments in Aging: 1979," part 1, pp. 59–61.

Senator Pryor chaired the second in the series of "Aging and Mental Health" hearings in Washington on May 22. The hearing continued the theme of coordination among physical, mental health, and social services by inviting witnesses from the Administration on Aging, the National Institute on Mental Health, the Veterans' Administration, and private organizations representing various aging and mental health groups. Just as the Arkansas hearing focused on coordinating efforts at the State and local levels, the hearing in Washington sought to identify collaborative activities among agencies and organizations at the national level aimed at overcoming barriers the elderly face in obtaining mental health services. Witnesses gave particular emphasis to how community mental health programs, due for reauthorization in 1980, might be improved, as well as discussing needed changes in the medicare reimbursement system.

B. THE MENTAL HEALTH SYSTEMS ACT

The 1980 session of Congress reauthorized and expanded community mental health programs by enacting the Mental Health Systems Act (Public Law 96–398), which was signed by the President on October 1, 1980. The final version of the legislation retained the emphasis on underserved populations which had been the main focus of the bill introduced by Senator Kennedy on behalf of the administration in 1979 (S. 1177). Based on the recommendations of the President's Commission on Mental Health, S. 1177 sought to encourage community mental health centers and other public and private nonprofit entities to meet the mental health needs of underserved populations, including the chronically mentally ill, the elderly, severely disturbed adolescents and children, and others.

As reported by the Senate Labor and Human Resources Committee on May 15, 1980 (S. Rept. 96–712), S. 1177 authorized a Federal-State-local partnership in the delivery of mental health services (title I). The legislation established a series of competitive grants to local, public, or private nonprofit agencies of State agencies to provide services to underserved, or priority population groups, including the elderly and the chronically mentally ill, or to undertake prevention activities or linkage among physical and mental health services (title II). It also mandated a bill of rights for mentally handicapped persons (title III).

The provisions in title II for the chronically mentally ill and the elderly were of particular interest to the aging community. The special grants for services for the chronically mentally ill could be awarded to a public or private nonprofit entity, which would agree to provide either identification of the target population and assessment of needs, case management, or support services. When the Health Subcommittee of the Senate Labor and Human Resources Committee was considering the Mental Health Systems Act, S. 1177, Senator Richard Schweiker amended the bill to include a new grant section to provide mental health services for elderly individuals. The special grants for services for the elderly could be awarded to entities which agree to provide outreach and at least one of the following:

—Identification and assessment of needs of the elderly and services not currently being provided.

—Assuring the availability of appropriately trained personnel.
—Coordination of mental health and support services with services available through related Federal programs, such as the Older Americans Act, title XX, medicare, medicaid, etc.
—Providing mental health services to the elderly in nursing homes, intermediate care facilities, boarding homes, senior centers, etc.; or
—Differential diagnosis for elderly individuals to distinguish between their medical and mental health needs.

Each of the sections for special service grants provided that the State could apply to be the sole contractor for services, and requirements for States selecting this option were delineated. Elderly individuals could also benefit from the provisions for prevention activities and linkage between physical and mental health care.

1. SENATE COMMITTEE ON AGING AMENDMENTS

S. 1177 came before the Senate on July 24. Senator Pryor offered a series of amendments which were cosponsored by members of the Special Committee on Aging, including Senators Chiles, Glenn, Burdick, Domenici, and Heinz. Based on testimony of the "Aging and Mental Health" hearings, the amendments sought to insure that a comprehensive range of essential services would be provided for the elderly under the new grants for special services. The first amendment required applicants for the contracts to serve the chronically mentally ill to provide all three of the services identified as essential to their successful entry into the community—identification and assessment, case management, and community support services. The second established a priority among the services to the elderly by requiring grantees to provide not only outreach, but also differential diagnoses and either services not currently being provided or services in settings where the elderly reside—nursing homes, intermediate care facilities, senior centers, etc. The provisions for coordination of mental health and support services with related Federal programs and management to assure appropriately trained personnel were retained as options for grantees, particularly in areas where the basic core of services were being provided.

Two of Senator Pryor's amendments focused on the training needs of mental health professionals to serve the elderly and other priority population groups. The final amendment gave the State mental health agency, in cases where the State elected to be the sole contractor for mental health services, the responsibility for certifying that standards for boarding homes are being enforced. All of the amendments were unanimously adopted.

In further floor action on S. 1177, the Senate adopted a compromise substitute to the bill of rights and advocacy provisions of the bill. The amendment, offered by Senator Robert Morgan, replaced the extensive requirements for States to establish specific programs for rights of mental patients and grievance procedures and suggested a model for State bills of rights and advocacy.

2. HOUSE ACTION

The House of Representatives in 1980 proceeded with a more limited extension of community mental health programs than encompassed by by the Senate-passed bill or proposed by the administration. H.R. 7299, reported by the Interstate and Foreign Commerce Committee on May 15 (H. Rept. 96–977), provided for special grants for services to the chronically mentally ill, severely disturbed adolescents and children, Indian tribes or organizations, services in ambulatory health care centers, and for innovative projects, but it included no separate provisions for grants to the aged. Instead, the elderly were included in the section for services to priority population groups. The committee contended that older Americans would be adequately served as one of the priority population groups and by the provisions for ambulatory health care centers.

3. FINAL PROVISIONS OF PUBLIC LAW 96–398

In the House-Senate conference (Conf. Rept. 96–1367), the emphasis on special services for the elderly was retained. As signed into law on October 7 (Public Law 96–398), the Mental Health Systems Act contained the following provisions of potential benefit to the elderly:

- —Grants may be made to any State mental health authority, community mental health center, or public or private nonprofit entity which provides identification of the chronically mentally ill; assistance to such persons in gaining access to essential mental health, medical, and social services; case management; and coordination of services to the chronically mentally ill (section 202).
- —Grants may be made to any public or private nonprofit agency which provides at least the following services: Locating elderly individuals in need of mental health services; medical differential diagnosis; the specification of mental health needs of the elderly and the mental health and support services designed to meet these needs; services to the elderly in the community or services to older persons in nursing homes and intermediate care facilities, and staff training in such facilities (section 204). The law provides, however, that in areas where there is a community mental health center, the grants are restricted to the CMHC or the State agency.
- —Grants may be made to any public or private nonprofit agency which has an affiliation with a health care center and provides mental health services which include at least 24-hour emergency services, outpatient services, consultation and education (section 206).
- —Grants may be provided to any public or private nonprofit entity for projects for prevention of mental illness and promotion of mental health and to demonstrate the effectiveness of intervention techniques (section 208).

The final version of the legislation also retained provisions to encourage States to adopt a bill of rights and advocacy programs for mental patients, although like the Senate-passed version, there are no

Federal mandates or sanctions for States which do not establish and guarantee the rights of the mentally ill (title V).

C. MEDICARE REIMBURSEMENT FOR MENTAL HEALTH SERVICES

A wide range of proposals for expansion of mental health benefits under medicare was introduced in the 96th Congress. Although the House of Representatives attempted to remove restrictions in current medicare coverage of mental health, the 1980 session ended without congressional enactment of amendments to the medicare law relating to mental health services.

The importance of adequate medicare reimbursement for mental illness was stressed by Senator Heinz in his remarks before the Senate on July 24, 1980, during consideration of the Mental Health Systems Act.

> . . . the services that this bill (S. 1177) would provide and the amendments that Senators Pryor, Chiles, myself, and other members of the Aging Committee have offered today are vital steps toward providing the critically based outpatient care for our needy older Americans. But more must be done to remedy the fragmented, acute-care oriented Federal health care delivery system that is inadvertently, and unintentionally assuring that millions of our elderly do not receive the care needed to allow them to be productive, active participants in our society.
>
> The present medicare and medicaid systems stress treatment for acute disorders, whereas the elderly suffer from chronic disorders related to longevity. I believe it is time our medicare system be revitalized to serve the purpose for which it was intended—that is, meeting the health care needs of the elderly and the disabled.

1. EARLY PROPOSALS

Some of the bills introduced during the 96th Congress to expand medicare coverage for mental health services include:

—S. 123, introduced by Senator Inouye, which would have licensed psychologists to be providers for purposes of medicare reimbursement.

—S. 458, sponsored by Senator Stafford, designed to establish provider status for community mental health centers, partial hospitalization in lieu of inpatient hospitalization up to 60 days per year, and provide reimbursement up to 25 visits per year for outpatient services by community mental health centers.

—S. 1289, authored by Senator Heinz, would have eliminated the 190-day lifetime limit for inpatient psychiatric care under part A of medicare, replaced the current 50–50 percent copayment for outpatient mental health services under medicare part B with 80–20 percent copayment (the standard for physical health services), eliminated the $250 annual ceiling for part B outpatient mental health services, extended provider status to qualified community mental health centers, provided for reimbursement of services by CMHC's on a cost-related basis, and allowed coverage of partial hospitalization by CMHC's.

—S. 2176, introduced by Senator Inouye, would have included social workers as qualified providers under medicare.

—S. 3029, introduced by Senators Matsunaga and Inouye, took a different approach from the aforementioned bills on the issue of expanded medicare coverage for mental health. This legislation would have authorized the creation of a National Professional Mental Health Services Commission, comprised of 13 Presidential appointees, to represent the various mental health professions—psychiatrists, psychologists, clinical social workers, and psychiatric nurse specialists. The Commission would have been charged with evaluating and recommending to the Secretary of Health and Human Services combinations of patient characteristics, therapeutic techniques, mental health professionals, and treatment settings which are safe, effective, and appropriate for specific mental health problems. Had the bill been enacted, medicare reimbursement would have ceased after 1980 for any mental health service rejected by the Commission in concurrence with the Secretary. Beginning in 1984, medicare payment could have been made only for those services approved, for reimbursement. The bill also would have raised the annual limitation for covered outpatient services from $250 to $1,000 and reduced the beneficiary copayment for mental health services from 50–50 percent to 80–20 percent.

2. NO FINAL ACTION

The 96th Congress adjourned without hearings by the Senate Finance Committee or Senate action on any of these legislative measures. The House, however, did take steps toward expansion of medicare benefits for mental health services. The medicare amendments (H.R. 3990) reported by the House Ways and Means Committee on November 5, 1979 (H. Rept. 96–588, pt. 1) and by the Interstate and Foreign Commerce Committee on March 18, 1980 (H. Rept. 96–588, pt. 3), contained the following provisions for extension of medicare coverage for mental illness:

—The ceiling on reimbursement of outpatient mental health services was raised from $250 to $750 per year.

—The beneficiary copayment was reduced from 50 to 20 percent for outpatient mental health services, the same amount used for physical health services.

—Payment was authorized for services performed by qualified psychologists; and

—Cost-related or other reasonable reimbursement was authorized for services provided by qualified community mental health centers.

Although the 96th Congress did not take up either the House (H.R. 3990) or Senate (H.R. 934) versions of the medicare amendments, provisions for changes in the medicare program were incorporated in recommendations by the House Ways and Means Committee (H. Rept. 96–1150, part 1) and the Interstate and Foreign Commerce Committee

(CP 96–IFC 51) for spending reductions in the omnibus budget reconciliation bill (H.R. 7765). The Senate Finance Committee reported only the savings portions of its version of the medicare amendments, and H.R. 934 contained no provisions for expanding medicare mental health coverage. In conference, most of the spending provisions of the House bill were dropped, including the coverage increases for mental illness under medicare (Conf. Rept. 96–1479).

D. OUTLOOK FOR 1981

Mental health will be a significant issue in the 1981 White House Conference on Aging. Consideration of issues such as long-term care and health promotion and disease prevention will include discussion of the chronically mentally ill and activities to promote mental health among older persons in the community setting. In preparation for the Conference, a Miniconference on Mental Health of Older Americans was held in San Diego, Calif., on November 17–19, 1980, by the American Psychiatric Association, the American Psychological Association, the American Nurses' Association, and the National Association of Social Workers. Recommendations by these organizations have been submitted to a technical advisory committee for the White House Conference and will be distributed to the delegates at regional and national meetings of the Conference.

During 1980, the Department of Health and Human Services developed a national plan for the chronically mentally ill. The task force developing the plan was comprised of representatives of all parts of the Department related to mental health services and reimbursement, including the Health Care Financing Administration, the National Institute on Mental Health, the National Institute on Aging, etc. The final draft of the recommendations were submitted to the Secretary in September. Whether these strategies or new ones proposed by the Reagan administration are pursued, the issue of the chronically mentally ill and deinstitutionalization will remain important in the coming years.

Continued focus on medicare reimbursement for mental health services can be expected in the 97th Congress. Although it is hard to predict whether the new Congress will consider actual expansions in coverage, or support legislation designed to evaluate the safety and effectiveness of mental health services, the cost of program expansions will be an important issue.

Chapter 4

LONG-TERM CARE ISSUES

CHAPTER HIGHLIGHTS

Few concrete actions were taken during 1980 to develop a comprehensive statement of Federal policy toward long-term care services for the elderly and disabled, but the incremental development of community-based and home care services continued. Amendments to liberalize the medicare home health program were signed into law and new bills to broaden home care services were introduced. Grants and contracts were awarded to a number of States to conduct new "channeling" demonstrations and develop State long-term care plans.

New questions were raised about the future of Federal nursing home policies, as budget pressures halted the development of Federal rules to expand nursing home resident's rights and require comprehensive patient care management in all federally funded nursing homes. Congress also approved a controversial amendment to repeal Federal requirements for State medicaid nursing home payments.

Preparations for long-term care policy discussions during the 1981 White House Conference on Aging also reflected a growing concern about Federal budget pressures, with little room for significant expansion of direct Federal funding for long-term care services. Participants in a number of long-term care forums indicated their belief that State and local governments, as well as private voluntary efforts, will be faced with many challenges in the years ahead.

I. CAPACITY BUILDING: EXPANDING AND DELIVERING COMMUNITY-BASED SERVICES

Amendments to expand medicare home health services were signed into law at the end of 1980 and new bills were introduced which, if enacted, would increase the supply of community and in-home services. Efforts to improve the long-term care data base through additional research and to develop education and training opportunities for service providers were also underway.

Discussed below are a number of initiatives which have either begun during this past year or will be the subject of further congressional consideration during 1981. Other capacity-building activities in long-term care (ongoing Health Care Financing Administration (HCFA) and Administration on Aging (AoA) demonstrations, HCFA medicare-waiver hospice care projects, and AoA programs with local health planning agencies, for example) are discussed in part 2 of this report, report of the Department of Health and Human Services.

Impact of 1978 Amendments

Amendments to the Older Americans Act in 1978[1] authorized special demonstration activities to assist State and local governments in the development of comprehensive long-term care service programs for the elderly. The 1978 amendments also required increased coordination of all activities of the Administration on Aging and the network of State and area agencies on aging with programs and activities of the HCFA (which administers the medicare and medicaid programs) and Federal, State, and local health planning systems.

In fiscal year 1980, Congress appropriated $20.5 million to fund a series of capacity-building activities in long-term care, with primary emphasis to be given to the development and testing of new models of comprehensive community long-term care programs.[2] Activities were to be jointly funded through AoA and HCFA, with a $10-million allotment from AoA by special authorization and $10.5 million to be obligated through the HCFA overall research and demonstration authority. The office of the Assistant Secretary for Planning and Evaluation was to assure that all efforts were coordinated throughout the Department.

In June 1980, the Department notified the Committee on Aging[3] of its intent to obligate up to $14 million of earmarked appropriations to support and evaluate a series of long-term care "channeling" demonstrations; approximately $1.5 million to support 1-year State system development grants for statewide long-term care plans; and $3 million for national surveys to gather new information on the characteristics of the long-term care population, services currently available to them, and estimates of further needs. Additional amounts from the appropriation would be directed toward continuing current long-term care demonstration projects within HCFA and AoA.

The administration's budget request for fiscal year 1981 for this special long-term care initiative, as submitted to Congress in January 1980, was for $20.5 million to continue existing initiatives, and fund up to 10 additional channeling demonstrations.[4] In a revised budget submitted by the administration later in the year, however, the amount requested for the long-term care activities was reduced to $15.5 million.[5] The full $15.5 million was approved by Congress as part of a continuing appropriations bill for fiscal year 1981.[6] In a colloquy on the Senate floor during debate on the continuing resolution, Senator Lawton Chiles noted the Senate Appropriations Committee intent that priority continue to be given to the long-term care demonstrations, and pointed to the "unique coordination and cooperation they are forging between health programs funded under medicare and medicaid and social services supported by title XX of the Social Security Act and the Older Americans Act."[7]

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[1] Public Law 95–478.

[2] Public Law 96–38. See U.S. Congress. Senate. Appropriations Committee. "Authorizing Appropriations for the Departments of Labor, Health and Human Services," fiscal year 1980. Washington, S. Rept. No. 96–247, p. 149.

[3] Letter to Senator Lawton Chiles, chairman, Senate Special Committee on Aging, from John Palmer, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, June 3, 1980.

[4] The Budget of the U.S. Government, fiscal year 1981. Executive Office of the President, Office of Management and Budget, Washington, 1980.

[5] Fiscal Year 1981 Budget Revisions, March 1980. Executive Office of the President, Office of Management and Budget, Washington, 1980.

[6] H.J. Res. 637, Public Law 96–536. The continuing resolution, however, is only effective through June 5, 1981.

The administration's budget request for fiscal year 1982 asked for an appropriation of $10.5 million for HCFA and $10 million for AoA to restore the joint demonstration initiative to the original $20.5 million level.[8]

A. FIRST CHANNELING DEMONSTRATION CONTRACTS AWARDED

In September 1980, the Department of Health and Human Services awarded a total of $10.4 million to 12 States to establish demonstration projects in local communities to plan and provide comprehensive long-term care services. Each project is now in the process of developing a system to screen potential recipients of long-term care services, make an assessment of each person's service needs, develop an individually tailored plan of care, make arrangements for the appropriate support services, and provide followthrough and advocacy services to each individual.

States receiving the initial demonstration awards are funded for a period of 2 years under the contracts negotiated in fiscal year 1980. An additional 3 years of funding could be received under the demonstration program design. States included in the initial round of funding were Florida, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania and Texas.

B. STATE SYSTEM DEVELOPMENT GRANTS

A total of $1.5 million in 1-year grants was awarded to 15 additional States to develop statewide long-term care plans. These States will be able to participate in the demonstration program next year, or later if the demonstrations are continued.

States receiving 1-year grants for developing State long-term care plans from fiscal year 1980 funds include California, Delaware, Illinois, Idaho, Colorado, Washington, Oregon, Minnesota, Rhode Island, Wisconsin, Arkansas, South Dakota, North Carolina, New Hampshire, and the District of Columbia.

In both the channeling demonstration contracts and the 1-year State system development grants, the Department required that administration be through a State-level agency or unit of government. Each State's Governor was to designate a single State unit to assume responsibility for administering the contract or grant, but the project had to be developed by a consortium of each State's agency with responsibility for medicaid, title XX social services, and Older Americans Act programs.[9]

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[7] Chiles, Lawton. "Long-Term Care Demonstrations." Remarks in the Senate. Congressional Record, Dec. 10, 1980, p. S16093.

[8] Budget of the U.S. Government, Fiscal Year 1982. Executive Office of the President, Office of Management and Budget, Washington, 1981.

[9] "Revised Notice of Intent To Initiate National Long-Term Care Channeling Demonstration Program," Federal Register, vol. 45, No. 57, Friday, Mar. 21, 1980, p. 18483. "National Channeling Demonstration Program: Announcement for Long-Term Care System Development Grants," Federal Register, vol. 45, No. 100, Wednesday, May 21, 1980, p. 34250.

C. ROBERT WOOD JOHNSON FOUNDATION GRANTS

The Robert Wood Johnson Foundation, a private philanthropic organization with a strong emphasis on research and development activities in the delivery of health care services, has also made the development of coordinated systems of community services for the elderly a priority. In February 1980, the Foundation announced the award of $4.6 million in grants to eight area agencies on aging to coordinate community services for the elderly. Each of the eight grant awards will be administered through a coordinating agency created by an area agency on aging and a community voluntary organization providing services to the elderly. The coordinating agencies will provide case-finding, assessment, referral, and followup services. Grants were made to develop local programs in New York, Ohio, Nebraska, Maryland, South Carolina, Pennsylvania, Tennessee, and Illinois.

D. HOME HEALTH DEMONSTRATION PROGRAM

Since fiscal year 1976, a special home health demonstration program, administered by the Public Health Service, has awarded 345 grants to develop 85 new home health agencies and expand services in 260 additional home health agencies. An additional 77 grants have been awarded to train home health agency personnel.

The purpose of the program, as authorized by Congress,[10] is to provide seed money for development of home health agencies in underserved areas of the country, and expand the services of other home health agencies so that they may be certified for medicare participation. To be certified for medicare reimbursement for home health services, a home health agency must provide skilled nursing services and one additional skilled service—either physical or speech therapy. Though not required for medicare participation, it is desirable to have additional services, such as home health aide services, available through a home health agency. In some areas of the country, particularly rural areas, the supply of trained professionals in all these areas is limited. Therefore, the program also authorizes special training grants.

All but 1 of the 345 home health agencies receiving grants under this program were eventually certified by medicare and continue to provide services even though Federal grant support has been terminated.

If this grant program is to continue beyond this year, it will have to be reauthorized by Congress during 1981.[11] During fiscal year 1980 and fiscal year 1981, the administration requested no funds for the demonstration program, recommending its termination. Congress, however, continued appropriations for the program at a level of $5 million in fiscal year 1980, and $4 million for fiscal year 1981.[12]

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[10] The program was originally authorized by Public Law 94-66, through an amendment offered by then chairman of the Committee on Aging, Senator Frank Church, with an authorization of $8 million for demonstration and expansion grants. Public Law 94-640 extended the authorization through fiscal year 1977 with authorized levels of $8 million for demonstration and expansion grants and $4 million for training of home health personnel. An additional $12 million for fiscal year 1978 was authorized by the Health Assistance Programs Extension Act of 1977. Public Law 95-626 then authorized the program for an additional 3 years, through fiscal year 1981, incrementally increasing the authorization amounts to $13 million for demonstration and expansion grants and $2.5 million for training grants in fiscal year 1981.

[11] Senator Orrin Hatch, the new chairman of the Senate Labor and Human Resources Committee which has jurisdiction over this program, introduced a bill to reauthorize the demonstration program early in 1981 (S. 234). One major difference in the bill as introduced and the current program is that loans would be made available to proprietary home health agencies as well as grants to public and nonprofit agencies. The current program is limited to grants to public and private nonprofit agencies.

E. LONG-TERM CARE GERONTOLOGY CENTERS

During fiscal year 1979, the Administration on Aging awarded 22 grants to research institutes and universities to plan the development of long-term care gerontology centers. An additional seven planning grants were awarded during fiscal year 1980.

Once operational, a center would be a resource for educating and training professionals, paraprofessionals, and volunteers in long-term care programs and would provide assistance to States and communities to plan, manage, and set service priorities for the functionally impaired elderly.

Operational grants have been awarded to Brown University, Columbia University, the University of Southern Florida, the University of California at Los Angeles, and the University of Washington at Seattle. In January 1981, AoA announced the availability of up to $2.1 million to support up to five additional operational long-term care gerontology centers in fiscal year 1981, and $850,000 for support of two additional centers in fiscal year 1982.[13] These centers will be chosen from among those who earlier had received planning grants.

F. MEDICARE HOME HEALTH AMENDMENTS SIGNED INTO LAW

A number of amendments to expand the medicare home health program were signed into law on December 5, 1980.[14] Each will become effective July 1, 1981.

1. REMOVAL OF PRIOR 3-DAY HOSPITALIZATION REQUIREMENT

A medicare beneficiary will no longer have to be hospitalized for a period of at least 3 days before becoming eligible for home health benefits under medicare part A (hospital insurance). Under the new law, the part A home health benefit will be available, essentially, under the same conditions as the part B (supplementary medical insurance) home health benefit.

The change primarily will affect about 1.1 million medicare beneficiaries who do not have medicare coverage under part B, and who would have had no access to home health coverage unless hospitalized. (The prior law required the condition for which home health was being prescribed by a physician to be the same condition treated in the hospital. This will no longer apply.) The change in law is also expected to correct the potential for physicians to place a medicare beneficiary in an acute-care hospital in order to qualify the beneficiary for the home health benefit, thereby actually increasing the overall medicare costs for treatment of an illness.

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[12] The fiscal year 1981 funding is contained in Public Law 96–536, a continuing appropriations resolution passed by Congress on Dec. 16, 1980. The resolution, however, only authorizes appropriations through June 5, 1981.

[13] "Multidisciplinary Centers of Gerontology Program: Long-Term Care Gerontology Centers," Federal Register, vol. 46, No. 12, Monday, Jan. 19, 1981, p. 5072.

[14] Public Law 96–499. H.R. 7765, Omnibus Reconciliation Act of 1980. A number of amendments were originally introduced in the Senate on Feb. 26, 1979, as part of S. 489, Medicare Home Health Amendments of 1979, and some were reported by the Senate Finance Committee as part of H.R. 934 on Dec. 10, 1979. The amendments were introduced in the House and reported by the Ways and Means Committee as part of H.R. 3990 on Nov. 5, 1979. See "Developments in Aging: 1979," part 1, pp. 85–86, for discussion of original differences between Senate and House versions of the amendments.

2. ELIMINATION OF NUMBER-OF-VISIT RESTRICTIONS

Statutory limitations on the number of home health visits allowed under medicare part A and part B were removed. Before this change, the medicare part A home health benefit was limited to 100 visits per period of illness, and the part B benefit was limited to 100 visits per calendar year. Some medicare beneficiaries who had used up 100 visits under part A might have been able to continue receiving visits under part B, but this limitation also restricted the number of visits for those beneficiaries who did not carry part B insurance (1.1 million).

This change also was advocated to encourage more reliance on home health care as an alternative to other forms of health care.

3. REMOVAL OF $60 DEDUCTIBLE UNDER PART B

Requirements for the beneficiary payment of a $60 deductible, per calendar year, for home health services under medicare part B have been removed. With this change in the law, there is no patient cost-sharing for home health services under part B. Any medicare beneficiary utilizing other part B insurance benefits, however, still would have to meet the $60 deductible each calendar year, as well as a 20 percent coinsurance charge for each service.

4. OCCUPATIONAL THERAPY

Occupational therapy has been made a primary, or qualifying service under the medicare home health benefit. Prior to this change in the law, a medicare beneficiary had to have a prescribed need for skilled nursing care, physical therapy, or speech therapy, to qualify for the home health benefit. Occupational therapy services also were covered, but a beneficiary would have to have an additional need for one of the other three services to receive any occupational therapy. Under the new law, a prescribed need for occupational therapy alone would qualify a medicare beneficiary for the home health benefit.

This change adds more flexibility to the home health program, and is expected to effect primarily certain patients, such as stroke victims or those with vision problems, who do not necessarily need skilled nursing care but could remain in their homes with some help in adjusting to their new physical limitations. It also would mean that a recovering stroke victim, for example, who might be receiving both skilled nursing care and occupational therapy under the home health benefit, could continue to receive the occupational therapy services, if needed, after skilled nursing care was no longer needed.

5. NO STATE LICENSING REQUIRED FOR PROPRIETARY AGENCIES

The new law also eliminates the State licensing requirement for proprietary home health agencies. Prior to this change, a proprietary home health agency was required to be licensed by a State before being able to participate in the medicare program. Public and private nonprofit home health agencies, however, did not have to be licensed by a State in order to participate in medicare if they met the medicare conditions of participation for home health agencies.

Under the new law, any home health agency, regardless of sponsorship or tax status, must be licensed by any State which has a licensing program for home health agencies if it meets the requirements of the State licensing program. In those States without licensing programs, any agency, regardless of sponsorship or tax status, meeting medicare conditions of participation, could participate in the medicare program.

This change in law is expected to increase the number of medicare-certified home health agencies throughout the country. Currently, 26 States license home health agencies. One of these States, New York, excludes proprietary home health agencies from licensure. The growth of home health agencies could also be controlled by State certificate-of-need laws. Approximately 32 States currently have some form of certificate-of-need requirement for all or some types of home health agencies.

Each of the amendments discussed above is expected to expand the availability of home health services under the medicare program. Concerns about adequate program controls, however, also resulted in changes to the law to increase program administrative efficiency and safeguards against program abuse. These amendments, and their effect on medicare home health agencies, are discussed in chapter 3, section II, "Continued Emphasis on Controls for Medicare-Medicaid Abuse."

G. Home Health Aide Demonstrations

Public Law 96-499 also contained an amendment to require the Department of Health and Human Services to conduct demonstration projects, in up to 12 States,[15] to train and employ individuals participating in the program of aid to families with dependent children (AFDC) as home health aides. The demonstration program would be administered through a State medicaid agency, and Federal reimbursement for the costs of the program would be at a matching rate of 90 percent. Programs could be operated for a period of up to 4 years. A formal training program for the aides would have to be established by any State participating in the demonstrations, and approved by the Secretary of the Department of Health and Human Services.

House and Senate conferees urged quick implementation of these demonstration programs, asking that the administration issue any necessary guidelines to States by April 1, 1981. Guidelines are being developed by the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration.

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[15] The conference report accompanying this legislation made it clear that the conferees would be amenable to any request by the administration to increase the number of States participating in such demonstrations if early experience was favorable. The report also cited seven States (California, Georgia, Hawaii, Michigan, New Jersey, New Mexico, and New York) which had already "demonstrated an active interest and support" for this type of program. U.S. Congress. House of Representatives. "Conference Report To Accompany H.R. 7765, Omnibus Reconciliation Act of 1980." Washington, report No. 96-1479, p. 144.

H. House and Senate Hearings on New Bills

In addition to completing action on home health amendments, hearings were held on two new bills which would provide different approaches to expanding the supply of community and home care services for the long-term care population.

1. NONINSTITUTIONAL LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED ACT

In June, Senators Packwood and Bradley introduced the Noninstitutional Long-Term Care Services for the Elderly and Disabled Act.[16] As introduced, the bill would create a new title XXI of the Social Security Act to provide basic entitlements for home health, homemaker, home health aide, adult day care, and respite care services. The bill also would provide for a tax credit of $100 per year for families caring for dependent elderly relatives.

Existing sources of funding for these services currently authorized under medicare (title XVIII of the Social Security Act), medicaid (title XIX of the Social Security Act), and block grants to States for social services (title XX of the Social Security Act) would become part of the new title XXI.[17]

Full reimbursement would be provided for up to 50 home health, homemaker/home health aide, and adult day care visits in any calendar year. An unlimited number of additional visits for each of these services would also be covered, but subject to a copayment adjusted according to beneficiary income. Up to 336 hours of respite care visits in the home would be available per calendar year. Adult day services could be provided in a senior center, intermediate care nursing facility, hospital, rehabilitation center, or center for the handicapped.

All individuals age 65 or over, and all disabled individuals who currently qualify for benefits under the disability insurance provisions of the Social Security Act (title II) or for supplemental security income benefits (title XVI), or medicare and medicaid would be eligible for the home and community care services.

The actual receipt of services would have to be authorized by a preadmission screening and assessment team, under the general direction of a physician. The teams would assess health and functional status, develop a plan of care, periodically reassess status, and assist the beneficiary in obtaining appropriate services from community providers.

Implementation of the new program would first be through 10 3-year statewide demonstrations (1 in each of 10 Federal Department of Health and Human Services regions) with a joint evaluation of the demonstrations by the General Accounting Office (GAO) and the Department of Health and Human Services. The bill provides that the results of this evaluation, as well as an analysis of the costs of such a program done by the Congressional Budget Office, would be required before the program could be implemented.

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[16] S. 2809, introduced on June 10, 1980. Cosponsored by Senators Nelson, Heinz, Matsunaga, Cohen, Cochran, Javits, Williams, Melcher, Domenici, Randolph, Durkin, and Leahy. See Packwood, Robert. "Long-Term Health Care for Our Senior and Disabled Citizens." Remarks in the Senate. Congressional Record, June 11, 1980, p. S6645. Bradley, Bill. "Long-Term Home Care Act of 1980." Remarks in the Senate. Congressional Record, June 13, 1980, p. S6905.

[17] See p. 86 for estimates of current Federal funding for home care services now coming from these programs.

Hearings on the bill were conducted on August 27, 1980, by the Senate Finance Subcommittee on Health, which has jurisdiction over the measure, but no action was taken by the committee at the end of the 96th Congress.[18] It is expected that the bill will be reintroduced in 1981 for consideration by the 97th Congress.

The Senate Committee on Aging and the Committee on Labor and Human Resources also conducted a joint hearing on the bill, cochaired by Committee on Aging Senator Bill Bradley and the then-chairman of the Committee on Labor and Human Resources, Senator Harrison A. Williams.[19]

At Senate Finance Committee hearings on the bill, Senator Robert Packwood explained the reasons for combining home care funding under medicare and medicaid into a new title XXI:

> The current health care system often places people into specific entitlement groups. Those eligible for medicare are one entitlement group, those who qualify for medicaid represent another, and those eligible for title XX are yet another. While it is true that there may be limited overlap among the different entitlement programs, for the most part what we have established is a social and medical care system for the elderly and disabled that separates people by age or income class. Therefore, while persons 65 and over are eligible for both medicare and medicaid, only very low-income seniors can qualify for medicaid, and thus benefit from both programs.[20]

Senator Bill Bradley outlined three goals he expected the legislation would achieve if passed:

> . . . (The bill would) increase the availability of services and stimulate additional groups in the community to provide title XXI services by extending Federal reimbursement to community-based providers; assure a continuum of services available to the elderly and disabled under the Social Security Act by combining these services under one title and providing for service delivery on a comprehensive basis, and secure needed care for the elderly and disabled and also prevent the unnecessary and inappropriate placement of these individuals in institutions by funding screening, assessment, and case management services.[21]

2. MEDICAID COMMUNITY CARE ACT OF 1980

On December 19, 1979, Representatives Claude Pepper, chairman of the House Select Committee on Aging, and Henry Waxman, chairman of the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, introduced the Medicaid Community Care Act of 1980 (H.R. 6194). The Subcommittee on Health and the Environment, which has jurisdiction over the medicaid program in the House of Representatives, held 2 days of hearings on the bill during the year, but final action was not taken by the committee.[22] This bill is also expected to be reintroduced during the next session of Congress.

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[18] U.S. Congress. Senate. Subcommittee on Health of the Committee on Finance. "Comprehensive Community Based Noninstitutional Long-Term Care for the Elderly and Disabled." Hearing. 96th Congress, 2d session, on S. 2809, Aug. 27, 1980. Washington D.C., U.S. Government Printing Office, 1980. Ser. No. 96-98.

[19] U.S. Congress. Senate. Special Committee on Aging and Committee on Labor and Human Resources. "Home Health Care: Future Policy." Joint hearing. Nov. 23, 1980. Princeton, N.J. Hearing transcript not in print at time of publication of this report.

[20] Senate Finance Committee hearings, Aug. 27, 1980.

[21] Ibid.

As introduced, the bill would increase the Federal medicaid matching rate to States by 25 percent (up to a maximum Federal rate of 90 percent) for community- and home-based services provided to individuals at risk of institutionalization under a State medicaid program.

In order to receive the increased match rate for these services, a State medicaid plan would be required to:

—Provide a comprehensive medical and social assessment for each person who may require nursing home care.

—Provide skilled nursing and home health aide services, medical supplies and equipment, physical, occupational, and speech therapy, adult day health services, respite care, homemaker services, and nutrition counseling as part of the medicaid home health program.

—Provide payment for these services within limits set by the Department of Health and Human Services at a rate not to exceed the cost of skilled nursing care in each State; and

—Coordinate medicaid home health services with similar services provided under medicare, title XX, and the Older Americans Act.

The bill would also allow medicaid reimbursement for home health services for the aged, blind, and disabled with incomes slightly higher than a State's medicaid income eligibility level who would nevertheless qualify for medicaid nursing home payments in that State (those with incomes between 100 and 300 percent of the Federal supplemental security income standard). This provision would primarily affect those 17 States without a "medically needy" medicaid program, and would allow them to slightly expand medicaid eligibility for home health services without having to institute a full medically needy program for all medicaid-covered services.[23]

Under current medicaid law, State home health plans vary widely. Medicaid home health services must be made available to anyone entitled to skilled nursing facility services under a State medicaid plan. A nursing service, as defined by State nurse practice statutes, must be included in a medicaid home health program. Part-time or intermittent visits by a registered nurse, home health aide services and needed medical supplies, equipment, and appliances, must also be covered. All additional services which would be required under the Medicaid Community Care Act of 1980 are at State option. Under current law, States also have much more flexibility to set payment rates for home health services.

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[22] U.S. Congress. House of Representatives. Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. "Medicaid Community Care Act of 1980." Hearings. 96th Cong., 2d sess., on H.R. 6194. June 10 and 23, 1980. Washington, U.S. Government Printing Office, 1980. Ser. No. 96–165.

[23] This provision to "equalize" medicaid income eligibility levels for both nursing home care and community care was also included in the administration's legislative proposals for fiscal year 1981, as outlined in the fiscal year 1981 U.S. Budget and later sent to Congress in legislative form along with numerous additional amendments to medicare and medicaid. The administration's bill, however, was never introduced and no action was taken.

II. NURSING HOME ISSUES

The Federal involvement in nursing homes is tremendous. Of the approximately 26,000 nursing homes in the Nation, almost 20,000 voluntarily participate in the medicare and/or medicaid programs (5,500 in medicare and 18,500 in medicaid).

Tensions produced by conflicting demands to improve the quality of life for nursing home residents and contain escalating medicaid costs were evident throughout the year.

A review of all Federal requirements for nursing homes participating in medicare or medicaid was begun by the Health Care Financing Administration (HCFA) in 1978 and resulted in the first proposed changes to rules which originated in 1974. Considerable interest in the proposed regulations was generated during the public comment period, but no final decisions were made. Growing concerns about escalating medicaid costs were reflected in the debate on proposed changes and contributed to a slowdown in further development.

HCFA also began a review of Federal requirements for State survey and certification of nursing homes and the enforcement of required standards of care.

In Congress, the Federal mandate that States reimburse nursing homes on the basis of the costs of providing care was again challenged. A change in the law was made, but the impact of that change on the nursing home industry and the residents is unclear.

A. Nursing Home Regulations Proposed

Thousands of comments were received by the Department of Health and Human Services (HHS) on the proposed regulations for nursing homes participating in medicare and medicaid. New nursing home fire and safety rules were also proposed. Final rules on protection of nursing home residents' personal funds were issued in July, but did not become effective because of changes ordered by the Office of Management and Budget (OMB). The new administration has announced that all three of these initiatives will be fully reviewed before any further action is taken.

1. PROPOSED CONDITIONS OF PARTICIPATION FOR NURSING HOMES

In order to receive reimbursement for patient care from either medicare or medicaid, nursing homes must meet a set of minimum Federal standards for medical and rehabilitative care, living environment, staffing, and physical safety. These standards are referred to as "conditions of participation."

Current conditions of participation have been in force since 1974. During the past few years various criticisms have been leveled against the current standards including inadequate emphasis on the rights of nursing home residents; being vague and difficult to enforce; encouraging more attention to the paperwork required to prove compliance than to the outcomes of patient care; requiring both too little professional nursing care and too much professionalism among nursing home staff; and being generally out of touch with newer trends in nursing home care and more progressive standards as required by some States. Criticisms of lax requirements for resident safety and care were often voiced by members of the Committee on Aging.[24]

In 1978, HCFA began a review of all nursing home conditions of participation, soliciting comments from consumers, public officials, and nursing home service providers. On July 14, 1980, new conditions of participation for all nursing homes participating in medicare and medicaid were proposed to expand resident rights and make them a full condition of participation.[25]

Resident Rights

As proposed, all nursing home residents would be guaranteed rights to personal privacy, to retain personal property in their rooms, and to purchase personal goods with their own funds from sources outside the nursing home. Residents would be given the right of free and private access to visitors, including nursing home ombudsmen and State nursing home inspection and survey personnel. As proposed, all nursing homes would be required to allow at least 12 hours of visiting time each day, and nursing home ombudsmen must be given access to any resident who wished to see them.

Nursing homes would also be required to allow residents to choose their own physician and permit residents access to their own medical records. Residents would have the right to form patient councils, to be protected against unnecessary drug or physical restraints, and to be informed in advance of any transfer to another nursing facility or to another room within the same facility.

Current nursing home regulations specify a number of basic resident rights but are stated as standards rather than a condition of participation. Only violations of a full condition of participation can serve as the basis for Federal sanctions against a nursing home. Therefore, the proposed change would make violations of resident rights a basis for sanction.

Other Proposed Changes

Increased training for nurses' aides, who provide most of the resident care in nursing homes, would be required. Nursing homes would also be required to assist residents in obtaining services which are not available through the nursing home, such as dental and podiatric services.

Conditions of participation for skilled nursing and intermediate care facilities would be unified, providing a single set of standards for nursing homes providing both levels of care.

The proposed changes would also require a comprehensive patient care management system in all nursing homes, bringing together physician, nurse, rehabilitation, and social services specialists to develop a detailed individual plan of care for each resident. The resident and/or family would also have the right to participate, if they wished. A comprehensive assessment of each resident's physical, medical, and psychosocial condition would be required at the time of admission, and would be periodically updated as part of this process.

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[24] U.S. Congress. Senate. Special Committee on Aging. "Nursing Home Care in the United States: Failure in Public Policy." Introductory report and supporting papers 1 through 7. 1974–77. Also see the following more recent hearings chaired by members of the committee: U.S. Congress. Senate. Special Committee on Aging. "The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and 'Alternatives.'" Hearings, Chicago, Ill., Aug. 30, 1978. Chaired by Senator Charles Percy.

U.S. Congress. Senate. Subcommittee on Federal Spending Practices. "Problems in the Procedures Now Used for the Medicare and Medicaid Certification of Skilled Nursing Facilities and Intermediate Care Facilities." Hearings, Washington, D.C., July and November 1978. Chaired by Senator John Heinz.

[25] "Conditions of Participation for Skilled Nursing and Intermediate Care Facilities." Proposed rule. Health Care Financing Administration. Federal Register, vol. 45, No. 136, Monday, July 14, 1980, p. 47368.

Reaction to Proposals

The reaction to the proposed rules was mixed. Advocates for nursing home residents, including a number of the largest organizations representing the elderly, supported the resident rights proposals but were disappointed that requirements for expanded nursing care were not included. Nursing home resident advocates were also very supportive of provisions to require that ombudsmen be given access to any resident wishing to see them. Provisions of the 1978 amendments to the Older Americans Act [26] which required every State to institute a long-term care ombudsman program also directed each State to establish procedures for ombudsman access to facilities and resident records. This provision of the proposed regulations was meant to help establish that access.

Support was voiced, particularly for the proposed resident rights, by the National Retired Teachers Association/American Association of Retired People, the National Council of Senior Citizens, the National Council on the Aging, the Citizen's Coalition for Nursing Home Reform, and the American Association of Homes for the Aging. Others, including many providers, criticized the proposed rules as being too costly and difficult to implement or enforce.

As originally proposed, the rules were to be open for public comment for 60 days, but the comment period was extended for another 30 days as a result of considerable public interest. Over 3,500 separate comments were received by HHS.

The Department had estimated that the total cost of implementing the rules, as originally proposed, would be about $80 million a year, largely from changes required by the new patient care management system.[27] A separate study commissioned by the American Health Care Association and the National Council of Health Centers, however, estimated that the total costs of implementation would be $535 million a year, including $185 million alone to provide visitors access to residents.[28]

During the Senate Appropriations Committee's consideration of a continuing appropriations resolution for fiscal year 1981,[29] Senator Henry Bellmon expressed concern over the cost estimates and proposed an amendment to prohibit HHS from finalizing any part of the proposed regulations during fiscal year 1981. This amendment was modified by Senator Lawton Chiles to make issuance of any of the proposed rules in final form contingent upon receipt of revised cost estimates and an evaluation of the proposed regulations being prepared by the General Accounting Office (GAO).

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[26] Public Law 95-478. Final regulations governing the ombudsman program were issued on Mar. 31, 1980, Federal Register, vol. 45, No. 63, p. 21151.

[27] U.S. Department of Health and Human Services, Health Care Financing Administration, Health Standards and Quality Bureau. "Regulatory Analysis, Proposed Conditions of Participation for Skilled Nursing and Intermediate Care Facilities." Washington, June 30, 1980.

[28] Applied Management Sciences. "Examination of the Economic Impact of the Proposed Medicare and Medicaid Conditions of Participation for Skilled and Intermediate Care Facilities. Prepared for American Health Care Association and National Council of Health Centers." Silver Spring Md., Aug. 29, 1980.

[29] H.J. Res. 644. Public Law 96-536.

At the end of the year, HHS prepared to issue final rules on residents' rights alone, at an estimated cost of $20 million a year.[30] No final action was taken, since the GAO report was not submitted to Congress until February. It will be up to the discretion of the new administration to decide whether or not to continue their development.

2. PROTECTIONS FOR PERSONAL FUNDS

HHS proposed regulations in September 1978, to implement provisions of 1977 and 1978 amendments to medicare and medicaid which require that all nursing homes establish accounting systems for handling a resident's personal funds.[31] The final rules, to be effective October 1, 1980, were published in July 1980.[32] The rules required all nursing homes to provide residents with an explanation of their rights regarding personal funds and a listing of services—not provided by the nursing home as part of its basic rate—which could be charged to their personal funds. Nursing homes were also required to set up an accounting system for personal funds, if requested by a resident; to keep resident personal funds separate from facility funds; and to deposit any personal funds in excess of $150 in an interest-bearing account. Nursing homes would keep a written record of all financial transactions made from personal funds and provide residents with quarterly statements of account.

Shortly before the effective date, however, the Office of Management and Budget (OMB), which must review all Federal requirements for recordkeeping, ordered a revision. A full review and revision must be completed before any new final rules are issued. Since the law requires accounting systems for personal funds, however, some additional action must be taken unless the law is changed.

3. FIRE SAFETY RULES

New rules were also proposed by HHS in July to require all newly constructed nursing homes to have automatic sprinkler systems as a protection against fire.[33] These will also be reviewed by the new administration before any final rules are published.

4. ENFORCING THE RULES: HCFA PROPOSALS

States are responsible for enforcing nursing home conditions of participation. A designated State survey agency determines whether or not a nursing home meets conditions of participation and certifies eligibility for reimbursement from medicare and medicaid. A separate State agency, usually the medicaid agency, is also required to perform reviews of resident care to determine the appropriateness of the care and whether the resident's condition meets medicare or medicaid eligibility guidelines. These reviews are either made by medicaid "inspection of care" teams or, in some areas of the country, by medicare professional standards review organizations (PSRO's).[34] Further, each nursing home is required to have an internal utilization review committee.

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[30] Final regulations on residents rights were signed by then-Secretary Patricia Roberts Harris on Jan. 19, 1981, and withdrawn by the new administration on January 21. Federal Register, "Notice of Withdrawal of Secretarial Approval," vol. 46, No. 15, Friday, Jan. 23, 1981, p. 7408.

[31] Public Law 95–142 and Public Law 95–292.

[32] "Medicare and Medicaid Programs. Protection of Patients' Funds." Final regulation. Federal Register, vol. 45, No. 144, Thursday, July 24, 1980, p. 49440.

[33] "Medicare and Medicaid Programs, Automatic Extinguishment Systems for New Long-Term Care Facilities." Proposed regulations. Federal Register, vol. 45, No. 146, Monday, July 28, 1980, p. 50268.

Many States have been severely criticized for lax enforcement of nursing home regulations, particularly in the survey and certification process. The Federal Government, which by law has a responsibility to insure that State enforcement activity is adequate, has also been criticized for not exercising its oversight authority with enough vigilance.

Elements of the proposed conditions of participation cited above were directed toward clearing up some of the ambiguities thought to contribute to enforcement problems. Additionally, HCFA announced its intent to conduct a review of all Federal requirements for certification, medical care evaluation, and utilization review. Meetings were held in all 10 Federal regions from March through June, and comments on a number of specific issues related to nursing homes were requested, including the following:

—How conflicting determinations of nursing home compliance with the conditions of participation made by State survey teams and State inspection-of-care teams (or PSRO reviewers) could be resolved. Proposals included requirements for exchange of reports between teams and setting more specific guidelines for inspection-of-care reviews to make them more consistent with survey team guidelines.

—Whether or not all States should be required to integrate the functions and administration of survey and inspection-of-care teams. Both surveys could be performed under the jurisdiction of the same State agency and/or the comprehensive evaluation now done by inspection-of-care teams could be reduced to a screening review.

—Whether or not States should be given more flexibility for conducting utilization review in intermediate care facilities, including elimination of utilization review committees in nursing homes.

—Whether or not a nursing home resident and/or family should be able to participate in the survey and certification process, helping to make determinations regarding a nursing home's certification for continued Federal funding. (The proposed conditions of participation discussed above would give a resident the right to meet with survey personnel.) A nursing home resident's right to have a say in decertification of a medicaid facility has been the subject of court debate. Since decertification means a transfer of residents to another facility, with possibilities of lifethreatening "transfer trauma," attorneys argue on behalf of residents for their participation. A recent U.S. Supreme Court decision, however, held that the residents of a nursing home are not cor stitutionally entitled to a hearing prior to decertification of the facility by the State or Federal Government.[35]

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[34] Only about one-fourth of approximately 200 PSRO's are currently credentialled to perform long-term care reviews.

—Whether Federal regulations should allow States to survey nursing homes anywhere from every 3 months to every 2 years, based on past performance. (Currently, surveys are required every 12 months.) HCFA suggested that this would reduce administrative costs and paperwork as well as allow more concentration on those nursing homes which are frequently in violation of regulations. HCFA also suggested, however, that direct Federal surveys would be increased.

—Whether or not State surveyors should be required to meet minimum standards of skill and knowledge.

Many of HCFA's proposals were supported by the nursing home industry, so it is probable that this effort to revise Federal requirements for State enforcement activities will be continued by the new administration. No specific regulation changes, however, had been proposed by the end of 1980.

5. ENFORCING THE RULES: CONGRESSIONAL ACTIONS

Intermediate Sanctions

An amendment to authorize intermediate sanctions for nursing home noncompliance was signed into law in the 96th Congress.[36] The Secretary of HHS and State medicaid agencies are authorized to deny reimbursement for services provided to any new medicare or medicaid beneficiaries admitted to a nursing home after the home has been determined out of compliance with conditions of participation. Payments would be resumed once corrections were made. This "intermediate" sanction could be used only in cases in which the violations do not endanger the health and safety of residents. (If residents were in danger, the nursing home would be decertified immediately.)

Prior to the change in the law, the only sanction available was decertification of a nursing home, even if the violations did not endanger health and safety. Intermediate sanctions are supported by nursing home resident advocates and are seen as a way to provide a nursing home with incentives to improve conditions without having to subject residents to transfers to another facility.

Medicaid "Look Behind" Authority for HHS Secretary

The new law also authorizes the Secretary of HHS to question ("look behind") the results of a State nursing home survey and, if appropriate, terminate a nursing home's participation in medicaid.[37] Prior to this change, the Secretary had such authority only for medicare participation.

Congress also considered some changes in the compliance process which were not finally approved, including: (1) Repealing existing authority for medicare reimbursement to State survey and certification agencies for consultative services furnished to medicare skilled nursing facilities to help them remain in compliance with conditions of participation; and (2) continuing, until 1983, authorization for 100 percent Federal payment under medicaid for the costs of State nursing home inspectors.

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[35] U.S. Supreme Court, June 1980. *O'Bannon v. Town Court* (100 S.C., p. 2467).

[36] Public Law 96–499, effective Dec. 5, 1980.

[37] Ibid.

The failure to extend the authorization for 100 percent Federal funding of nursing home inspectors means that as of October 1, 1980, the matching rate became 75 percent.

B. Further Challenges to Medicaid Cost-Related Reimbursement

The level of medicaid reimbursement to nursing homes and the methods used to determine appropriate rates are set by States.

Until the 1972 amendments to the Social Security Act, only very general Federal criteria were set for these payments. Criticisms of widely varying rates among States, particularly concerns about arbitrarily low rates which encouraged poor care, led to a change in the law. In 1972, Senator Frank Moss, a member of the Committee on Aging, won approval of section 249(A) of Public Law 92–603, which required States to provide medicaid reimbursement to skilled nursing facilities and intermediate care facilities on a "reasonable cost-related basis." The law directs States to develop their own methods and standards for determining cost-related rates, but the Secretary of HHS must approve and verify these methods. The 1972 amendments made the change effective by July 1, 1976.

1. EARLY DELAYS IN IMPLEMENTATION

Implementation was resisted, however, and final regulations for cost-related reimbursement were not even issued until July 1, 1976. At the same time, the regulations gave States until January 1, 1978, to implement the new standards, even though the law had set 1976 as the deadline. When the GAO ruled that HHS could not delay implementation beyond the 1976 date mandated by law, the Senate approved an amendment offered by Senator Henry Bellmon, to change the implementation date to January 1, 1979, as part of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. The amendment was lated dropped in conference. A second amendment offered by Senator Bellmon later in the year was defeated on the Senate floor. As a consequence of the delays and confusion regarding intent, some States did not come into compliance fully until 1980.

2. FINANCE COMMITTEE DISCUSSES REPEAL

Early in 1979, during the Senate Finance Committee's discussions of ways to cut medicaid and medicare costs, a repeal of the "section 249" legislation was proposed. Initial estimates of medicaid savings from State reductions in nursing home rates and from lessened administrative reporting requirements, if the law was repealed, were between $50 and $75 million per year.[38]

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[38] U.S. Congress. Senate. Committee on Finance. "Proposals for Medicare-Medicaid Reform and Overall Hospital Revenues Limitation." April 1979, committee print No. 96–10. (A later analysis by the Congressional Budget Office could predict no cost savings.)

Immediate concern was voiced by national aging organizations and others[39] that a repeal would mean substantially lowered quality of nursing home care and a move away from long-sought reimbursement mechanisms which could link payment rates to the quality of care received by nursing home residents. They were particularly fearful of the removal of any Federal oversight authority over how rates were determined. Others expressed concern that a repeal of reporting requirements would mean that a provider would be able to demand inflated rates from State medicaid agencies, leaving the States without the tools needed to verify the reasonableness of provider costs.

A compromise amendment was fashioned within committee deliberations, giving States more discretion to develop their own rate setting methodology but requiring that rates were sufficient to meet the necessary costs of facilities "which were efficiently and economically operated and which would assure the reasonable availability of long-term care services."[40]

Before any amendments were reported by the Finance Committee, GAO issued a report analyzing the proposed revised language. GAO found the proposed change would "effectively remove HHS from the ratesetting process" and recommended that the Federal Government maintain some control over nursing home payment rates since at least half of medicaid funds spent on nursing homes are Federal funds. GAO also reported that detailed cost reports required under the current law "had been important in detecting and prosecuting nursing home medicaid fraud, and necessary for assuring accurate reimbursement." GAO recommended that a State still should be required to file cost reports with the Federal Government. Without cost reports, according to GAO, the assurances of rates adequate to meet costs incurred by "economically and efficiently operated" facilities could not be verified. Overall, GAO said that it expected the final effect of the proposed change would be to increase nursing home reimbursements.[41]

Further informal negotiations in the Senate resulted in additional modifications, and the amendment reported by the Senate Finance Committee in December 1979, added language to directing States to give some assurances of compliance to the Federal Government.[42]

3. SENATE PASSES MODIFIED AMENDMENT

The amendment did not reach the Senate floor until June 1980, as part of the Omnibus Reconciliation Act of 1980.[43] Still concerned about significantly reduced Federal oversight of the medicaid nursing home payment process, Senator David Pryor, a member of the Committee on Aging, engaged in a colloquy on the Senate floor with Senator David Boren, the original author of the amendment to delete the cost-related reimbursement requirement from the law. Senator Pryor said:

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[39] Among them the American Association of Homes for the Aging, the National Citizens Coalition for Nursing Home Reform, the National Council of Senior Citizens, the National Senior Citizens Law Center, and the American Association of Retired Persons.

[40] Senate Finance Committee press release.

[41] U.S. General Accounting Office. "Potential Effects of a Proposed Amendment to Medicaid's Nursing Home Reimbursement Requirements;" report to the Congress by the Comptroller General of the United States. Washington, 1979. HRD–80–1, Oct. 15, 1979.

[42] Section 227 of H.R. 934. U.S. Congress. Senate. Committee on Finance. "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979; Report To Accompany H.R. 934." Washington. Rept. No. 96–471.

[43] The amendment was section 565 of H.R. 7765.

> The abuses in nursing homes documented by the Senate Committee on Aging and by recent media exposés underscore the need for a vigilant effort by the Federal Government to clean up the nursing home mess. While, as a former Governor, I strongly support the rights of States to develop flexible programs to meet the needs of their citizens, I believe these documented abuses in nursing homes can only be overcome by the force of Federal actions.[44]

Senator Pryor recounted the difficulties encountered by many States during the 6-year period required to comply with the original 1972 amendments, and cited the "basic accountability" and improvements in nursing home quality of care which had been provided through compliance with the existing law. He also expressed his concern over what he anticipated would be lengthy court battles:

> Even if my fears of a loss of Federal oversight are not realized, it is very difficult to predict how many States may become involved in legal challenges to their existing reimbursement systems in response to a change in the law.[45]

Consumer organizations also continued to oppose the amendment, and when it was considered by House and Senate conferees at the end of the year, it was again modified, as described in the conference report:

> . . . to clarify that, while the States have discretion to develop the methods and standards on which the rates of reimbursement are based, the Secretary retains final authority to review the rates and to disapprove those rates if they do not meet the requirements of the statute. The conferees intend that the Secretary shall exercise this review in a timely fashion . . . The conferees would further note their intent that a State not develop rates under this section solely on the basis of budgetary appropriations. . . ."[46]

The new language became effective on October 1, 1980. It is still unclear, however, what the changes ultimately will mean to the nursing home industry or nursing home residents. The final estimate of medicaid cost savings was $2 million.[47]

III. CURRENT FEDERAL FUNDING AND PROJECTIONS OF NEED

There is a growing consensus concerning certain basic services and supports which may be needed by many elderly and disabled to permit as full and independent functioning within society as possible. There is not, however, as certain a recognition of how much of these needs are—or are not—now being met, or of who should provide for them. Nor are there accurate measurements of the full costs, including both public and private contributions, to personal care supports for the elderly and disabled.

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[44] Pryor, David. Remarks in the Senate. Congressional Record, June 30, 1980, pp. S8926–27.

[45] Ibid.

[46] U.S. Congress. House of Representatives. "Conference Report To Accompany H.R. 7765, Omnibus Reconciliation Act of 1980." Washington, Rept. 96–1479.

[47] Ibid.

Direct Federal expenditures for certain basic services can, however, be used as a measurement of the current Federal role. Analysis of data from a number of surveys and studies also provides some new estimates of the size of the potential long-term care population.

A. FEDERAL SPENDING ON LONG-TERM CARE SERVICES

Direct Federal expenditures (excluding State contributions) for basic long-term care services in nine specific programs now "targeted" at a long-term care population were about $6 billion in fiscal year 1980. Almost 71 percent of this amount ($4.265 billion) is for skilled and intermediate care nursing homes. Not included are support in personal care and boarding homes provided through the supplemental security income (SSI) program, or programs of the Veterans' Administration which support institutional and community care.

Federal payments for services through the *medicare home health* program were $735 million in fiscal year 1980. The growing demand for these services and recent changes in the law will increase expenditures, and estimates are that medicare home health expenditures will grow to $912 million in fiscal year 1981 and $1.15 billion in fiscal year 1982.[48]

Federal payments for long-term care services through *medicare skilled nursing home* benefits were $365 million in fiscal year 1980. Without change in current policies toward medicare payments for skilled nursing home services, medicare expenditures are expected to rise to $387 million in fiscal year 1981 and $431 million in fiscal year 1982.[49]

Title XIX of the Social Security Act authorizes Federal matching payments to States for a range of health services to low-income individuals of all ages. Although the average Federal share is 57 percent, many States have a much higher Federal matching rate since the rate is based on the size of a State's low-income population. Federal payments through the *medicaid* program for care in *skilled and intermediate care nursing facilities* during fiscal year 1980 were $3.9 billion. Estimated Federal medicaid payments for these services are expected to increase to $4.6 billion in fiscal year 1981 and to $5.2 billion in fiscal year 1982.[50] This program represents the single largest component of Federal funding for all long-term care services for the elderly and disabled.

The medicaid program also provides significant funding for home health, adult day care, and personal care services for the long-term care population. Data are no longer collected separately from State medicaid plans on home health and personal care expenditures, but in fiscal year 1978 home health payments were estimated to be $211.3 million.[51]

Title XX of the Social Security Act authorizes Federal matching payments to States (at 75 percent) for the costs of providing a wide range of social services to low-income individuals of all ages. Total Federal expenditures in this program are capped, by law, at $2.7 bil-

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[48] Source: Budget of the U.S. Government, fiscal year 1982, op. cit.

[49] Ibid.

[50] Source: Health Care Financing Administration, Department of Health and Human Services. Figures do not include medicaid payments to intermediate care facilities for the mentally retarded or other domiciliary care homes.

[51] Source: HCFA.

FIGURE 1.—DIRECT FEDERAL PAYMENTS FOR SELECTED LONG-TERM CARE SERVICES[1]

[Dollar amounts in millions; fiscal years]

Source of funding	Institutional care			Community-based and in-home services		
	1980	1981	1982	1980	1981	1982
Medicare (title XVIII of SSA):						
Home health services				$735	$912	$1,150
Skilled nursing facility	$365	$387	$431			
Medicaid (title XIX of SSA):						
Home health services				212		
Skilled and intermediate care nursing facility	3,900	4,600	5,200			
Social services grants (title XX of SSA):						
Homemaker/chore services				540	580	600
Adult day care and home-delivered and congregate meals				67		
Older Americans Act:						
Congregate and home-delivered meals (title III–C)				390	435	478
In-home services (title III–B)				32	32	32
HUD housing services: Congregate services (title IV, 1978 Housing Act)				10		

[1] All sources and explanations contained in accompanying text.

lion for fiscal year 1980, rising to $3.1 billion by fiscal year 1983. One of the fastest growing categories of services provided by States through the title XX program is homemaker and chore service. Services are provided to individuals of all ages, but a majority of recipients are elderly. Federal *title XX* payments to States for *homemaker/chore services* were $540 million in fiscal year 1980. Federal expenditures for this type of service, under current spending ceilings and State title XX plan allocations, are expected to increase to $580 million during fiscal year 1981 and $600 million during fiscal year 1982.[52]

The title XX program also makes significant payments for *adult day care services and home-delivered and congregate meals.* During fiscal year 1980, estimated Federal title XX payments for these services were about $67 million.[53]

A fourth significant, although smaller, source of Federal funding for community and in-home services is title III of the *Older Americans Act.* During fiscal year 1980, direct Federal expenditures for *congregate and home-delivered meals* were about $390 million (including Department of Agriculture commodity support). Future levels are subject to congressional appropriations action, but expenditures are expected to reach about $435 million in fiscal year 1981, and $478 million in fiscal year 1982.[54]

In-home services funded under title III of the *Older Americans Act* during fiscal year 1980 were about $32.1 million. Expenditures for fiscal years 1981 and 1982 will also be determined by congressional appropriations, but the administration's budget request assumed no increases.[55]

The Department of Housing and Urban Development administers a comparatively small program of funding for congregate meals and other essential "in-home" support services for some residents of public housing for the elderly and disabled. This program of congregate services, authorized by Public Law 95–557, was funded by Congress at a level of $10 million in fiscal year 1980. A continuing appropriations resolution has provided for an additional $10 million in fiscal year 1981, but the administration has requested a rescission of this amount and no funds have been requested for fiscal year 1982.

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[52] Source: U.S. Budget, fiscal year 1982 op. cit.

[53] Source: State title XX plans, Office of Human Development Services, Department of Health and Human Services. No estimates are available for future years.

[54] Source: U.S. Budget, fiscal year 1982 op. cit.

[55] Ibid.

B. The Long-Term Care Population

In its report to the new administration,[56] the Under Secretary's Task Force on Long-Term Care defined what it called a "target long-term care population" of approximately 6 million individuals who currently are either:

(1) Living in the community, but who need help with personal care and activities of daily living and/or help with maintaining a household (3.9 million—identified as the population in level III in the table below, as well as about 300,000 additional individuals in level IV).

(2) Living in institutions (1.8 million); or

(3) Disabled and living in board and care homes (0.6 million).

About half of the target group living in the community (2 million) have resources and living arrangements which can make it difficult for them to continue living outside a nursing home. Over 40 percent have family incomes below $6,000 a year, and about 20 percent live alone.

Based on projections of population growth, particularly among older Americans, the task force estimated that the target long-term care population (of 6 million) could increase from 25 to 50 percent by 1990—to between 7.5 and 9 million people.

If current trends of care are constant, the task force estimated that one-third of those included in this increase (from 2.5 to 3 million) will become institutionalized, bringing the institutional population to approximately 4.8 million.

Another one-third (from 2.5 to 3 million) will be added to the 3.6 million individuals with functional disabilities currently living in the community—bringing the population of those who are living in the community but who cannot maintain a household without help to approximately 6.6 million.

The table below illustrates these estimates, based on a classification of types of functional disability and assumptions of service and support needs. Further improvements in measurement of disability and functional impairment related to support needs will certainly mean that changes in classification and definitions of a "long-term care population" will be made in the future. The Federal Council on Aging, for example, is now preparing such estimates, and the Department of Health and Human Services is planning surveys to gather new long-term care data. These estimates, however, represent a refinement of earlier estimates prepared by the Congressional Budget Office which have been widely used.[57]

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[56] "Report of the Under Secretary's Task Force on Long-Term Care," Department of Health and Human Services, staff draft, Jan. 9, 1981.

[57] "Long-Term Care for the Elderly and Disabled," Budget issue paper, Congressional Budget Office, Congress of the United States, Washington, D.C., February 1977. The CBO estimated then that 1.6 million people of all ages were institutionalized in 1976, and that this institutionalized population would increase to 3 million by 1985. CBO also estimated that the range of noninstitutionalized functionally disabled individuals living in the community was between 3.9 and 8.3 million in 1975, and expected to increase to between 4.5 and 9.6 million in 1985.

There is very little information regarding the extent to which these needs are being met already or in what ways. In general, studies indicate a large proportion (about 80 percent) of the personal care support services now being provided to individuals living in the community come from a network of "informal supports," such as family and friends.

ESTIMATES OF POPULATION NOW LIVING IN THE COMMUNITY WITH SOME FUNCTIONAL LIMITATIONS[1] (NONINSTITUTIONALIZED)

Level of functional disability	Service/support needs	Number of people	Percent of group (within level) with incomes under $6,000 per year	Percent of group (within level) who are living alone
I. Some chronic conditions; no severe disability.	Health and rehabilitation services.	(2)	(2)	(2).
II. Cannot work; cannot engage in major activities.	Above, plus income support.	7.7 million (3.8 million aged 65 or older).	40 percent, or 3.1 million.	15 percent, or 1.2 million.
III. Cannot maintain a household without help.	All above, plus mobility assistance; household and community services.	3.6 million (2.1 million aged 65 or older).	41 percent, or 1.5 million.	20 percent, or 0.7 million.
IV. Full disability	All above, plus personal care and assistance with activities of daily living (bathing, dressing, eating, etc.).	1.6 million (1 million aged 65 or older).	36 percent, or 0.6 million.	11 percent, or 0.2 million.

[1] All information taken from analyses in Report of Under Secretary's Task Force on Long Term Care, Department of Health and Human Services, staff draft, Jan. 9, 1981.

[2] Not applicable.

IV. A MOMENTUM FOR CHANGE

A Task Force on Long-Term Care in the Department of Health and Human Services and preparations for the 1981 White House Conference on Aging all contributed to a sense of momentum for change in Federal long-term care policy during the year.

The shortcomings of the current system are no longer the subject of debate, and consensus is broadening on some long-range policy goals.

A. PREPARATIONS FOR 1981 WHITE HOUSE CONFERENCE ON AGING

Organization for a focus on long-term care issues in the 1981 White House Conference on Aging[58] began early in 1980, with the formation of a Long-Term Care Technical Advisory Committee. Members of the committee, with broad representation from a wide range of disciplines, met throughout the year to prepare a working outline of long-term care policy options and recommendations for use by conferees. A Mini-White House Conference on Aging was held in December, and a symposium on long-term care policy options was convened in June.

1. SYMPOSIUM ON LONG-TERM CARE POLICY OPTIONS

Preliminary plans for long-term care discussion at the 1981 White House Conference on Aging were put in motion early in 1980 through preparations for a national symposium on long-term care policy options, sponsored by the Administration on Aging. Papers analyzing the "state of the art" in six important issue areas were commissioned by a national steering committee in anticipation of the symposium, which was convened in Williamsburg, Va., in June 1980.[59]

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[58] Authorized by the 1978 amendments to the Older Americans Act, Public Law 95–478.

The symposium report, which is expected to be used during a series of regional White House Conference on Aging meetings early in 1981, expressed what may be a keynote message for conferees:

> Momentum for change is building, not only because of the growing numbers of people seemingly at risk for assistance, but also because of a realization by numerous visible constituencies (professionals, politicians, taxpayers, and persons in need of care) that the way in which long-term care services are financed, organized, and made available is fraught with problems. Much of the frustration has focused on our inadequacies in caring for those who suffer from chronic disabilities. Many of these persons are old but the problem cannot be limited or defined by age. The problems of long-term care have become a symbol of America's traditional rejection of dependency and our seeming callousness to the problems that accompany chronic illness and disability.[60]

The symposium identified the following major policy issues needing resolution:

(1) A lack of consensus about the nature and extent of public responsibility for meeting long-term care needs results in an inability to articulate a coherent set of goals and directions for future policy development. Since there is such a momentum for change, however, the development of Federal policy should proceed immediately on the basis of general consensus on goals and objectives. New information is still needed to develop a long-term perspective, including estimated costs, but the call for new knowledge should not be used to defer immediate steps toward change.

(2) Assumption of public responsibility for long-term care and subsequent programs should protect existing familial and informal care arrangements. Beyond financial support, however, few methods have been suggested to insure that care by families is not replaced, and this should be a high priority issue for further research and investigation.

(3) A definition of need must be developed, along with eligibility criteria, before any rational allocating of scarce resources can be derived. These criteria have not yet been developed, therefore, policy may have to follow three related courses: An initial target population for long-term care services linked to a demonstrated need for care

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[59] "The Extent and Nature of Public Responsibility for Long-Term Care"; "Health and Social Factors Relevant to Long-Term Care Policy"; "Allocating Long-Term Care Services: The Policy Puzzle of Who Should Be Served"; "Delivery of Services to Persons With Long-Term Care Needs"; "Finding the Money and Paying for Long-Term Care Services"; and "Cost Estimation and Long-Term Care Policy: Problems in Forecasting the Undefined."

[60] "Federal Policy Directions in Long-Term Care," draft report prepared for symposium on long-term care policy options, June 11-13, 1980, Williamsburg, Va. Center for Study of Welfare Policy, the University of Chicago. Revised Sept. 3, 1980.

based on the presence of functional limitation; no arbitrary age cutoff for publicly supported long-term care eligibility; and the immediate goal may have to be to direct public support and subsidy first to low-income individuals who need care.

(4) The current long-term care system places an overemphasis on institutional and acute care. Financial incentives for States and localities should be altered to make noninstitutional care more attractive. Federal policy must rely less on medicaid as part of an attempt to demedicalize long-term care.

(5) A major shortcoming of long-term care is the pervasive absence of personal care services and other social supports which can assist the individual to live in the community. Federal policy should therefore focus on expanding the availability of social supports to obtain a more appropriate and cost-effective balance between personal care services and medical care as well as housing and income maintenance. Further, the social support system should retain its own integrity, and should not be conceived as a subsidiary of medical care.

(6) There is a wide variation in current State and local financing and availability of long-term care services. Federal policy should seek to reduce these imbalances through mandates requiring service development at uniform minimum levels in all States. No single model of service delivery, however, should be insisted upon by the Federal Government, and any developing policy should look to the diverse approaches and experiments now underway in many States and local areas.

(7) In order to achieve coordination and access to the multiple human services needed by many long-term care clients, long-term care must be conceptualized as requiring at least four major types of support (income adequacy, health care, social supports, and adequate housing). These services must be capable of tailoring to individual needs and conditions. Policy and program alteration should proceed on multiple fronts, through coordinated change in current systems of income support, health care, personal and social services, housing, and institutional care.

(8) Scant attention is being given to housing as a critical component of long-term care, and Federal policy in long-term care should have an explicit focus on increasing the range and number of supported housing opportunities for the long-term care target population.

(9) Efforts to coordinate services, including case management, will be necessary under any new approach, but they are not a strategy for change. Federal policy should not place primary emphasis on coordination of existing services.

(10) Much more care and consideration must be given to all the manpower implications of proposed long-term care policies, including issues of overprofessionalization and making caretaking roles more attractive.

(11) Regardless of the Federal policy pursued, ongoing efforts must be devoted to resource development, including initiation and development of new services in many communities, and staff training and development. This need is particularly acute in rural areas.

2. MINI-WHITE HOUSE CONFERENCE ON LONG-TERM CARE

In December 1980, a Mini-White House Conference on Long-Term Care was sponsored by a broad coalition of long-term care service providers, including national organizations representing home health agencies, nursing homes, hospitals, and State and area agencies on aging.[61] The final report of the conference [62] focused on issues of immediate concern:

> Long-term care has been identified repeatedly as one of the major areas of concern for the 1981 White House Conference on Aging. While the problems which exist in the current system of long-term care have been enumerated and analyzed from many perspectives over the past several years, a consensus has yet to be reached among those in the field of long-term care on a resolution of the problems at the Federal, State, and particularly, the community level. Needs assessment, cost factors, and utilization are but a few long-term care issues which provoke far-reaching public debate. Recognizing these as major problems, the conveners of the miniconference on long-term care saw a need for policy direction and a need to stimulate action to strengthen community-based long-term care specifically for individuals. An attempt was made to move away from a discussion of whether we should allocate substantial resources to long-term care, to a discussion of how we can develop a viable program to most effectively provide individuals with the care they need.
>
> To best meet the changes that long-term care will inevitably undergo in the next several years, and to facilitate some of those changes, the long-term care community has recognized that it must begin to conduct a serious dialog and to work together on the basis of full cooperation.
>
> Several significant assumptions provided the parameters for these discussions: The budgetary situation facing long-term care will become even more severe and resources that have long been taken for granted will simply not be available; the role of the Federal Government in the provision of services will become less vital; the current system will continue to be inadequate to meet the needs of the increasing number of elderly individuals. These assumptions have several noteworthy implications for the future, about which there was a consensus among the participants at the conference: There is no one system which will be appropriate for every individual in need of services in each community; the emphasis on the community and on the informal support structures will increase sizably; and a partnership needs to

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[61] The conference was coordinated by the American Association of Homes for the Aging and the National Homecaring Council. Additional sponsors were the American College of Nursing Home Administrators, American Health Care Association, American Hospital Association, Council of Home Health Agency Community Health Services of the National League of Nursing, Home Health Services and Staffing Association, National Association of Area Agencies on Aging, National Association for Home Health Agencies, National Association of State Units on Aging, and National Council of Health Centers.

[62] "The Mini-White House Conference on Long-Term Care." Draft final report, Jan. 16, 1981.

be created between the Government and the private sector on the financing and delivery of services.[63]

In general, conferees recommended that:

—Focused and comprehensive planning for a continuum of long-term care services, institutional and noninstitutional, should occur at Federal, State, and local levels. Different levels of emphasis and responsibility should be prescribed for each level, but maximum flexibility should be preserved at the State and local levels.

—At all levels, provision must be made for the fullest involvement of the consumer of long-term care services. Recipients of any system must be assured of options and freedom of choice. At all levels, provision must also be made to include the broadest range of existing planning systems (health, mental health, e.g.) and service providers, including voluntary and private providers.

—Responsibilities of a long-term care system should include, at each level, coordination of current system efforts, development and enforcement of quality of care standards, and development of service priorities, to assure meeting the real needs of those in need of long-term care services with scarce resources.

Conferees also urged support for increased and improved utilization of long-term care research and evaluation efforts to support development of a long-term care system.

B. THE UNDER SECRETARY'S LONG-TERM CARE TASK FORCE

Late in 1979, the Secretary of the Department of Health and Human Services (HHS) announced the formation of a departmentwide task force on long-term care policy to develop policy goals, coordinate research and demonstration activities, and review and initiate proposals for long-term care reform.[64] The task force was chaired by the Under Secretary of the Department, with membership at the assistant or deputy assistant secretary level from Department offices responsible for planning, budget, and administration of the medicare, medicaid, social security, and public health programs.

In a report [65] to the new administration's incoming Secretary of HHS, the task force reiterated major shortcomings of the current long-term care system:

—The system is fragmented with no mechanisms to effectively identify and coordinate services.

—Community-based services are appropriate alternatives to institutional care for some, but the supply of these services is far too limited.

—The major source of long-term care assistance is private and should continue, and ways to provide support to families who are providing care must be found.

—States are seeking flexibility among funding sources and are experiencing difficulties due to differences in Federal programs.

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[63] Ibid.

[64] In a letter to Senator Lawton Chiles, chairman, Senate Committee on Aging, Nov. 27, 1979. See also, "Developments in Aging: 1979," part 1, p. 85.

[65] Report of the Under Secretary's Task Force on Long-Term Care, op. cit.

—Criteria used to assess quality of long-term care services is lacking, and little progress has been made on applying criteria in noninstitutional settings; and

—The best strategies for prevention and management of chronic disabling conditions have not been determined.

The task force concluded that "there is no single answer to this multifaceted problem" and recommended that the Department:

—Work to assure balance, or "neutrality," in its programs so they do not lead to unnecessary or inappropriate institutionalization. Institutional care, however, should remain available to those for whom it is the preferred alternative.

—Encourage and support the development of alternatives to nursing homes for all those for whom it is appropriate in terms of cost and quality.

—Give high priority to quality assurance mechanisms in both institutional and community settings.

Noting that "certain solutions require more budgetary resources than will be available over the next few fiscal years, and that (the Department's) information base is inadequate to adopt others at this time," the task force recommended that HHS move immediately to develop a comprehensive long-term care data base through coordinated departmentwide research and demonstration activities and conduct thorough reviews of basic approaches to quality assurance in institutional and community settings and current long-term care financing systems. The task force also recommended developing joint working plans between the Departments of Housing and Urban Development, Veterans Administration, and Agriculture, to find the best ways to expand the range of service-enriched living environments (such as congregate housing with services) with emphasis on innovative private sector and government interactions; identifying ways to make current HHS programs more supportive of spouses, families, or friends providing care to the elderly and disabled; and making a systematic and thorough examination of screening and assessment to identify the most appropriate locus of responsibility and point of intervention.

The task force challenged earlier estimates of the extent of inappropriate institutionalization, which were believed to be within a range of 15 to 40 percent of all individuals in acute care hospitals and nursing homes, as too high. They conceded, however, that "practical experience in a number of areas and demonstration projects indicate that where people can be linked to appropriate alternative services, a significant proportion can be maintained in the community."

Among other conclusions:

—Evaluations of newer forms of congregate housing which emphasize service packages and architectural design features which promote independence seem promising because of their effect on residents, their flexibility, and their costs. Very little is known however, about the cost-effectiveness of congregate housing in preventing institutionalization compared to home-based services.

—Current evidence is inadequate to conclude that there is a surplus or shortage of nursing home beds and other long-term care services and settings; that is, whether needs exceed current utilization. Choices of living arrangements available to the elderly, however, have narrowed in the past 50 years. (The task force explains that its conclusion here is based on a lack of information about a number of factors which would affect decisions about the supply of services, such as how many individuals are now inappropriately placed, the effect of a lack of alternatives, consumer preferences, whether or not shifts would take place if alternatives were available, and whether or not public reimbursement is more in control than the actual supply of beds. The task force also notes that the supply situation differs by State.)

No recommendations were made to the new administration beyond continued research and attention to long-term care issues.

Chapter 5

ENERGY ASSISTANCE PROGRAMS

CHAPTER HIGHLIGHTS

The trend continued. During 1980, energy prices steadily climbed to record rates as the full impact of decontrol, additional OPEC price hikes and the war in the Middle East affected the world's oil supply. As the price of crude oil escalated, the burden on the consumer rose accordingly. A Department of Energy advisory committee projected that during 1980, the low-income household was spending, on the average, at least 35 percent of its income on energy. The advisory committee reported that low-income households will continue to pay four times more the percentage of their income on energy than the average American household, but will use less than 50 percent of the total energy consumed by that average household.[1]

The demand for assistance to combat rising energy prices was even greater in 1980. A major new program, the Home Energy Assistance Act, was enacted to respond to the growing need. However, administrative and financial problems curtailed the effectiveness of the program. Under new regulations, States struggled to draft plans which would serve their various parochial needs.

The unusually hot summer of 1980 documented the serious impact of severe heat on individuals, especially the elderly. The Federal Government attempted to respond to this critical situation which took the lives of approximately 2,000 persons. However, gaps in the Government's ability to act were evident. At a minimum, there was a recognition that assistance for "cooling" as well as heating is justified under the Government's program in cases of medical necessity.

Legislation to reauthorize the weatherization program for low-income households under the Community Services Administration died at the end of the 96th Congress. However, Congress approved a 1-year extension of a small-scale weatherization program for the low income under the Department of Energy. Prospects for expansion of a weatherization program by the 97th Congress are uncertain.

I. A YEAR OF ANALYSIS AND PLANNING

During 1980, the States concentrated on implementing an energy assistance program which was loosely authorized by language contained in the 1980 appropriations bill (Public Law 96–126). In fact, a good portion of the program was handled by the Federal Government, which issued energy assistance payments to elderly and disabled supplementary security income (SSI) recipients.

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[1] U.S. Department of Energy, Economic Regulatory Administration, Fuel Oil Marketing Advisory Committee, "Low-Income Energy Assistance Programs," Washington, D.C., July 1980.

While administering the 1980 program, the States also had the task of drafting a State plan for the much more comprehensive 1981 energy assistance program. The new program, the Home Energy Assistance Act of 1980, was enacted as title III of the Windfall Profits Tax Act (Public Law 96–223).

The Home Energy Assistance Act of 1980 contains a provision which requires priority attention to households with an elderly member. This amendment, sponsored by the entire Senate Committee on Aging, necessitated special planning by the States to provide outreach and benefits for the elderly.

The Senate Committee on Aging, in an effort to hear from the elderly and program administrators about recommendations for the 1981 program, continued the committee's series of hearings on "Energy Assistance and the Elderly."

At a hearing in Pennsauken, N.J., Senator Bill Bradley, who chaired the meeting, described the burden of energy prices on older persons. "By last winter," he said, "which was relatively mild, low-income older persons were using almost 48 percent of their limited incomes for energy costs. Almost 50 percent of their income therefore was going for heat and electricity. It was no longer difficult for many elderly to pay their utility bills, it was impossible."[2] This burden was put in more human terms by an elderly woman who testified before the committee in Maine:

> My grandsons finished off two rooms upstairs, but I keep them closed off to save heating costs. In the winter, I close off the bedroom too, and heat only the kitchen, sitting room, and bath. During the winter, I sleep on the couch. I always keep the thermostat set at 65 and wear insulated underwear, heavy sweaters, slacks, and wool socks. Even doing that, my heating bill jumped from $450, 2 years ago, to $923 last winter. Without the ECAP program (energy crisis assistance program) I would have frozen to death for sure. I hated to ask for help last winter; my husband and I had made it for 48 years on our own, but I couldn't cut back any more without my pipes freezing.[3]

In addition to the fear of freezing pipes, many elderly also fear illness brought on by extreme cold to which they are far more susceptible than other age groups. As Senator William Cohen, who chaired the Maine hearing, pointed out:

> Although willing to conserve, many older persons cannot reduce the temperatures in their homes below a certain point without potential danger to their health—even the risk of hypothermia. For these elderly poor, being too cold is not merely an inconvenience.

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[2] U.S. Senate Special Committee on Aging hearing on "Energy Assistance and the Elderly," May 23, 1980, Pennsauken, N.J.

[3] U.S. Senate Special Committee on Aging hearing on "Maine's Rural Elderly: Independence Without Isolation," June 9, 1980, Bangor, Maine.

Program administrators across the country made similar recommendations to the Committee on Aging which would help meet the needs of the elderly under the new program. One suggestion was to make funds available at earlier dates in order to allow States the necessary time to prepare for the program.

An administrator in New Jersey suggested utilization of the elderly as outreach workers and laborers for the low-income weatherization program.

As the director of Maine's energy program pointed out:

> Conservation and crisis assistance programs are not the total answer for Maine. We need to integrate public education, weatherization, housing rehabilitation, and fuel assistance. Presently, elderly people whose homes are dilapidated because they can no longer afford to maintain them are being forced into nursing homes. Houses are being vacated and left to rot at a time when there is a housing shortage. Something must be done to stop this trend of spending millions of dollars to keep people barely warm in inadequate housing.[4]

An area agency aging director from Florida suggested that States be required to maintain a list of high-risk elderly residents in order to provide assistance more expeditiously. He explained:

> Florida's service providers have, in the past 7 months, been focusing their attention on identifying those persons with physical or mental limitations that restrict individual ability to perform the normal activities of daily living and which impede individual capacity to live independently with the provision of services. These functionally impaired individuals are the people most likely to need extraordinary attention in any crisis situation and were the first persons contacted as the temperatures reached critical levels.[5]

The growing importance of the home energy assistance program benefits to the consumer was underlined for the Aging Committee by a fuel dealer from New Jersey, who explained that many fuel merchants, especially the small companies, could no longer let consumers bills ride. He explained:

> Our members (Fuel Merchants Association) have traditionally operated assistance programs of their own. Before the recently announced tightening of credit terms by the major oil companies, it was historical practice for home heating oil distributors to refrain from terminating service to any customer during the heating season because of a failure to pay any outstanding bills within a reasonable period. In practice, this resulted in extension of credit as long as 60 to 90 days for senior citizens and the economically disadvantaged, often extending into late spring and summer. . . . The recent dramatic increases in the price of home heating oil,

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[4] U.S. Senate Special Committee on Aging hearing on "Energy Equity and the Elderly," Oct. 24, 1980, Boston, Mass.

[5] U.S. Senate Special Committee on Aging hearing on "Energy Assistance and the Elderly (Impact of the 1980 Heat Wave)," July 25, 1980, Washington, D.C.

> coupled with the tightening of credit terms by the major suppliers, foreclosed to members of our association the luxury of extending 60- to 90-day credit terms to great numbers of our customers. Slow payments across the board by virtually all end-consumers meant that it was no longer possible to carry on our historical practice of carrying fixed- or low-income customers for long periods, if we were to keep our businesses financially afloat. The new market conditions have forced our members to borrow so heavily to cover the financing of inventory that we could no longer depend on lending institutions to help finance our accounts receivable as well.[6]

In response to these remarks, Senator Bradley pointed out that the Home Energy Assistance Act requires the fuel suppliers to carry the resident for 60 days. This requirement was described by the fuel dealers as a major problem and a disincentive for dealers to supply households who receive assistance under the Home Energy Assistance Act.

In summary, the hearings substantially documented that the unprecedented energy crisis which grips the world is a major problem for program administrators, local officials, and fuel dealers, but a cruel, often unbearable burden, for the elderly.

The Home Energy Assistance Act of 1980 is intended by the Congress to help alleviate this burden.

II. THE HOME ENERGY ASSISTANCE ACT OF 1980

A. A New Authorization

The Home Energy Assistance Act of 1980 (Public Law 96–223) significantly expands upon the 1980 program. Major provisions in the program are described below:

—The new law requires that "priority be given to households with lowest incomes and to eligible households with at least one elderly or handicapped individual . . ." The former Secretary of Health and Human Services, Patricia Roberts Harris, described this "priority" as ease of application process, access to assistance, and timing of benefits or guarantees of assistance if program funds are inadequate.[7] The regulations governing the new law reflect the Secretary's definition but add that the "State plan must describe how priority will be given to eligible households with elderly or handicapped persons."[8]

—Eligibility, under the new law, is "an income equal to *or less* (emphasis added) than the lower living income standard." This level, which differs among regions of the country and between metropolitan and nonmetropolitan areas, will result in different eligibility levels among the States. In addition, eligibility levels will differ within the States as the continuing resolution which authorizes the program's funding for 1981 (Public Law 96–536) allows States to use either the lower living income standard or 125 percent of the poverty level in determining eligibility for single-person households. This allowance was added when it became evident that in some regions of the country, 100 percent of the lower living income standard would be a lower amount than the 125 percent of poverty level used under the 1980 program. Many States determined that some persons receiving assistance during 1980 would be ineligible in 1981 under the lower living income standard. This allowance is especially important for elderly persons as persons aged 60 and over make up the largest percentage of one-person households.

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[6] U.S. Senate Special Committee on Aging hearing on "Energy Assistance and the Elderly," May 23, 1980, Pennsauken, N.J.

[7] Letter to Senator Lawton Chiles, chairman, U.S. Senate Committee on Aging, from Patricia Roberts Harris, Secretary, Department of Health and Human Services, Sept. 15, 1980.

[8] Federal Register, vol. 45, No. 196, Oct. 7, 1980, p. 66695.

—States have the option of utilizing automatic eligibility for recipients of SSI, AFDC, food stamps, and certain veterans benefits. State agencies can make payments directly to the recipients or through vendors (energy suppliers) in contrast to last year when SSI recipients were paid directly by the Federal Government. States can still exercise the option of Federal payments to their SSI recipients, but many are now expected to make the payments through State channels in order to better target energy assistance. However, in most States this will mean each recipient must apply to receive the payment and cannot expect to receive a "bonus check" in the mail as they did last year.

—The need for adequate outreach efforts is underlined by the above described required application process. The Home Energy Assistance Act requires that each State plan includes "outreach activities designed to assure that all eligible households, particularly households with elderly or handicapped individuals, households with individuals who are unable to leave their residences, households with migrants, households of individuals with limited English proficiency, households with working poor individuals, households with children, and households in remote areas, are aware of the assistance under this title . . ." In addition to this requirement for every State, the Director of the Community Services Administration (CSA) is authorized to enter into agreements with national aging organizations for the purpose of providing special outreach efforts on behalf of elderly persons. For this effort, the Director is authorized to use up to $3 million for each fiscal year of the program.

—The amount of assistance for households may differ. The law allows States to determine each household's benefit level based on the household's income, household size, energy costs and the climatic condition of the region. However, the law requires that the highest level of assistance be provided to or on behalf of those households with the lowest income and highest energy costs.

—States may use up to 7½ percent of their allocation for administering their programs. States are not required to match the Federal dollars but must pay, from non-Federal sources, all administrative costs which exceed the allowable 7½ percent Federal share.

—States are allowed to provide assistance to a household to help meet the rising costs of "cooling," but only when households show that cooling is a medical necessity in accordance with standards established by the Secretary of Health and Human Services. In addition, States are allowed to set aside up to 3 percent of their allocation for weather-related emergencies. These funds, unlike the assistance payments, can be used for cash payments as well as for goods and services necessary to respond to the emergency situation.

—The Home Energy Assistance Act specifically disregards any assistance payments or allowances under this program as income when determining benefit level and eligibility for other programs. Considerable misunderstanding about this provision arose chiefly due to the use of vendor payments when the recipient receives a reduction in utility bills, but no direct cash assistance, and resulted in different interpretations by various States and agencies. The food stamp program was most seriously affected by this provision. As of January 1, 1981, a recipient is eligible for a shelter deduction of $115 per month. Therefore, if one's shelter expenses are reduced by a vendor who has received an energy assistance payment on behalf of that resident, the resident could receive a smaller food stamp allotment.

To clarify congressional intent on this issue, the Senate-House conferees determining appropriations on the continuing resolution for fiscal year 1981, included language specifying that any assistance under the Home Energy Assistance Act shall not result in a reduction of benefits provided under the Food Stamp Act. In remarks on the House floor, Congressman Silvio Conte of Massachusetts further clarified the legislative intent, stating:

> It appears that beneficiaries under the home energy assistance program who receive their energy benefits in the form of direct vendor payments will have their food stamp benefits reduced accordingly. Meanwhile, beneficiaries receiving those same energy assistance payments in the form of cash will not have their food stamp benefits reduced by the amount of energy assistance they receive.
>
> Clearly, this double standard is not the intention of the authorizing legislation, nor the intention of the conferees. It is the stated intention of Public Law 96–223 authorizing the home energy assistance program that other benefits not be reduced as a result of these energy assistance benefits.[9]

B. APPROPRIATIONS DEBATES

The authorization for the new Home Energy Assistance Act (Public Law 96–223) provided for a $3.1 billion level for fiscal year 1981. The President's original budget request (January 1980) called for a level of $2.4 billion for 1981. The President's revised budget (March 1980), influenced by an election year and pressures to "balance the budget," reduced the request to $2.2 billion, only $400 million above the 1980 level of $1.6 billion.

The "balance the budget" mood also persuaded members of congressional Budget and Appropriations Committees to reconsider funding levels for many programs, including energy assistance. The House

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[9] Conte, Silvio. Remarks on conference report on H.J. Res. 637 (continuing resolution). Congressional Record, vol. 126, Dec. 13, 1980; p. H12425.

Budget Committee recommended only $1.8 billion for fiscal year 1981 and the House Appropriations Committee concurred with this level. In the Senate, the Budget Committee recommended a $2 billion level. During the markup of the continuing resolution for fiscal year 1981 (Public Law 96–536), members of the Senate and House Appropriations Committee, after extended debate, finally agreed upon a level of $1.85 billion.

Much of the debate on the energy assistance programs during the markup of the continuing resolution centered on the allocation formula for the program. The House of Representatives ignored the formula contained in the authorization legislation (Public Law 96–223) and instead weighted the formula in favor of the colder States. The sunbelt Members of the Senate insisted upon a more equitably weighted formula which would take into consideration the needs for cooling assistance. Members argued that record high temperatures of the summer which resulted in nearly 2,000 deaths, documented the need for cooling assistance. Conferees finally agreed upon a compromise which retained the House formula weighted in favor of the cold States, but added a hold-harmless provision which assured that no State would receive less than 75 percent of the allocation they would have received under the authorization formula.

In addition, the conferees agreed to allocate $87.5 million of the total $1.85 billion to the Community Services Administration (CSA) to support the energy crisis intervention program (ECIP), formerly the energy crisis assistance program (ECAP). The ECIP program, administered by local community action agencies, provides goods and services to low-income households in weather-related emergency conditions. This program, the original energy assistance program for the low-income established in 1976, is intended to complement the Home Energy Assistance Act which provides only for cash assistance to the resident. However, the program will be smaller-scale than in the past several years when the funding level was $200 million. The 1981 amount of $87.5 million will be distributed to the States by the same formula as the Home Energy Assistance Act.

Based on the allocation formula approved by conferees under the continuing resolution (Public Law 96–536), States will receive the following amounts for the Home Energy Assistance Act and the energy crisis intervention program:

	HHS	CSA	Total State allocation
Alabama	$15,076,782	$597,415	$15,674,198
Alaska	9,623,855	381,344	10,005,199
Arizona	7,291,310	288,917	7,580,227
Arkansas	11,504,297	455,856	11,960,153
California	80,882,545	3,204,959	84,087,504
Colorado	28,201,219	1,117,469	29,318,688
Connecticut	36,789,478	1,457,778	38,247,256
Delaware	4,883,091	193,492	5,076,583
District of Columbia	5,713,468	226,395	5,939,864
Florida	23,855,973	945,289	24,801,262
Georgia	18,861,795	747,396	19,609,191
Hawaii	1,899,493	75,267	1,974,760
Idaho	11,000,348	435,887	11,436,235
Illinois	101,826,954	4,034,878	105,861,832
Indiana	46,104,377	1,826,879	47,931,256
Iowa	32,674,799	1,294,734	33,969,533
Kansas	15,005,729	594,600	15,600,328
Kentucky	23,992,570	950,702	24,943,272

	HHS	CSA	Total State allocation
Louisiana	15,413,687	610,765	16,024,452
Maine	23,833,718	944,408	24,778,125
Maryland	28,169,247	1,116,202	29,285,450
Massachusetts	73,591,153	2,916,039	76,507,192
Michigan	96,675,763	3,830,763	100,506,526
Minnesota	69,649,410	2,759,848	72,409,258
Mississippi	12,925,992	512,191	13,438,183
Missouri	40,673,651	1,611,687	42,285,339
Montana	12,902,720	511,268	13,413,988
Nebraska	16,158,946	640,296	16,799,242
Nevada	3,424,511	135,696	3,560,206
New Hampshire	13,929,307	551,947	14,481,254
New Jersey	68,317,949	2,707,089	71,025,038
New Mexico	9,128,213	361,704	9,489,916
New York	223,068,441	8,839,054	231,907,495
North Carolina	33,243,961	1,317,287	34,501,248
North Dakota	14,016,247	555,392	14,571,639
Ohio	90,081,158	3,569,453	93,650,611
Oklahoma	13,858,652	549,147	14,407,799
Oregon	21,857,131	866,086	22,723,217
Pennsylvania	119,820,643	4,747,875	124,568,518
Rhode Island	12,113,523	479,997	12,593,520
South Carolina	11,974,035	474,469	12,448,504
South Dakota	11,383,649	451,075	11,834,725
Tennessee	24,303,957	963,041	25,266,998
Texas	39,688,375	1,572,646	41,261,021
Utah	13,105,171	519,290	13,624,462
Vermont	10,440,512	413,704	10,854,216
Virginia	34,313,289	1,359,659	35,672,948
Washington	35,951,971	1,424,592	37,376,563
West Virginia	15,877,699	629,151	16,506,851
Wisconsin	62,694,479	2,484,260	65,178,739
Wyoming	5,247,030	207,913	5,454,942
Total	1,753,022,273	69,463,251	1,822,485,524

III. THE LOW-INCOME WEATHERIZATION PROGRAM

The erratic history of the low-income weatherization program continued in 1980. This program, designed to provide weatherization and insulation to the homes of the low-income, began in 1974 with the enactment of the original Community Services Administration (CSA) program under the Economic Opportunity Act (Public Law 88–452). In 1976, additional authority for a similar program under the Federal Energy Administration (FEA), was included in the Energy Conservation and Production Act (Public Law 94–385). During 1977 and 1978, the two programs operated concurrently, each with separate funding and regulations. In 1979, the authorizations for both programs continued, but only the FEA program was funded because of pressures from the administration to consolidate all energy-related programs within the new Department of Energy.

In February 1980, the Senate passed the Economic Opportunity Amendments of 1979 (S. 1725). This legislation substantially expanded the scope and funding levels for the low-income weatherization program.[10] Although slanted toward authority under CSA, the bill left it up to the administration to decide whether CSA or DOE should have jurisdiction.

The House of Representatives counterpart to the Senate bill (H.R. 6619) stalled when it ran into committee jurisdictional battles among three committees. Although reported by the House Education and Labor Committee on May 13, 1980, the bill was never reported by the

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[10] For a detailed description of S. 1725, see U.S. Senate Special Committee on Aging report, "Developments in Aging: 1979," part 1, chapter IV, p. 111.

Banking, Finance and Urban Affairs Committee or the Interstate and Foreign Commerce Committee. It died with the closing of the 96th Congress.

However, an authorization for a low-income weatherization program in 1981 was approved by Congress.

Adding to the confusion over jurisdiction between CSA and the DOE, the Congress, as a part of the Energy Security Act of 1980 (Public Law 96–294), commonly referred to as the "Synfuels Bill," approved a 1-year reauthorization of the DOE's weatherization program. The legislation extends the authority under the Energy Conservation and Existing Buildings Act, but makes several changes.

The new law repeals the priority given to community action agencies for administering this program at the local level. The priority provision is replaced with language allowing local management by community action agencies or other public, nonprofit entities with "experience and performance in weatherization or housing renovation activities, experience in assisting low-income persons in the area to be served, and the capacity to undertake a timely and effective weatherization program. . . . In making such selection, preference shall be given to any community action agency or other public or nonprofit entity, which has, or is currently administering an effective program under this title or under title II of the Economic Opportunity Act of 1964."

The 1-year extension reduces the emphasis on utilizing volunteers and Comprehensive Employment and Training Act (CETA) workers for manpower for the program by allowing the Secretary of Labor to raise from $800 per dwelling to $1,600 the amount available to cover the costs of paying persons who install weatherization materials in areas where there are insufficient volunteers and CETA workers to perform such tasks. The law also allows the hiring of qualified workers for conducting specific weatherization activities which require special skills.

In addition, the new law increases the limit per dwelling from $100 to $150 for incidental repairs as may be necessary to make weatherization efforts effective.

To support the 1-year extension, Congress approved $181.9 million for the program in 1981 as a part of the Interior and Related Agencies Appropriations Bill (Public Law 96–514).

The new 1-year authorization only supports the low-income weatherization program through fiscal year 1981. Thereafter, the 97th Congress must decide whether to authorize the program under DOE or CSA. If both programs are continued, the Appropriations Committees will determine which program to support.

IV. THE HEAT WAVE OF THE SUMMER OF 1980

The summer of 1980 witnessed record high temperatures for record long periods of time. Continuing severe heat, which exceeded 100° in 10 States for at least a month, was blamed for the deaths of approximately 2,000 persons. The majority of the dead were elderly; thousands more senior citizens were hospitalized.

On July 25, 1980, the U.S. Senate Committee on Aging and the Senate Subcommittee on Aging of the Labor and Human Resources

Committee called an emergency hearing to hear from representatives of the affected States and to discuss with the administration the effectiveness of Federal programs attempting to respond to the crisis.

Senator Thomas F. Eagleton (D.-Mo.), cochairman of the hearing, pointed out:

> The severity of the 1977–78 winter made us all aware that adequate home heating is a necessary aspect of shelter; lack of heating poses a very real threat to health and safety. This summer's searing heat wave, which has held Midwestern and Southern States in its stranglehold for more than 1 month, has tragically demonstrated that air-conditioning, too, can be a life and death matter.[11]

Senator Lawton Chiles (D.-Fla.), the other cochairman pointed out:

> The committee has learned from the National Institute on Aging that older persons are far less able to adjust their body temperatures to extreme heat and cold, and therefore, are in far greater danger of being exposed to weather-related illnesses and death. We have learned from the U.S. Surgeon General that heat is particularly dangerous for persons suffering from chronic conditions such as heart disease, blood pressure, and respiratory illnesses. One or more of these conditions often afflict our older citizens.[12]

Representatives of programs which serve the elderly reinforced statements of the chairmen. An area agency on aging director from Arkansas described for the committees what happened in Arkansas during the heat wave:

> Inflation-eroded incomes may be totally insufficient to support even a $5-per-month utility bill increase. Living on $238—SSI—per month takes careful management.
>
> Many elderly are too frail to raise their windows.
>
> Some have had their homes weatherized for winter and their windows are permanently puttied shut. Or they are afraid to remove plastic weatherstripping for fear of being unable to afford replacement cost when bitter cold winter weather returns.
>
> Some elderly have air-conditioners, but do you think they are plugged in? Absolutely not. Who is going to pay the utility bill?
>
> And most important of all, many of the elderly had rather die than leave home. Thus, in spite of 24-hour emergency heat shelters located in senior centers throughout the State, we go in their homes and find them—dead.[13]

Similar cases were reported by a service provider from Missouri. She explained:

> For people in fair health, able to take care of themselves, the heat was uncomfortable and inconvenient; for the frail

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[11] U.S. Senate Committee on Aging and the Subcommittee on Aging of the Labor and Human Resources Committee: joint hearing on "Energy Assistance and the Elderly (Impact of the 1980 Heat Wave)," July 25, 1980, Washington, D.C., p. 2.

[12] Ibid, pp. 1 and 2.

[13] Ibid., p. 22.

> elderly it was deadly. These are the individuals who have difficulty coping with the usual tasks of daily living, and the added demands of coping with the heat are simply beyond their capacity. They could not go to a cooler place, they could not go out and buy a fan, they could not move their beds to a cooler spot unless someone helped them. They did not survive.
>
> It is important to keep that fact in mind as we look at ways to deal with a heat wave. It is primarily a problem of the elderly and the assistance provided must be geared to the characteristics of the elderly. Essentially, the assistance was directed to two approaches—to change the immediate environment of the older person to make it a more livable environment, or to change the person to a more livable environment.[14]

Responding to the crisis needs of victims in States affected by the heat wave were a variety of Federal, State, and local programs. However, the Federal energy crisis assistance program (ECAP) under the Community Services Administration (CSA) and the Home Energy Assistance Act administered by the Department of Health and Human Services (HHS) were responsible for providing approximately $30 millions of unspent 1980 fiscal funds to those States who met new standards prescribed for the crisis. Distribution of the identified unobligated 1980 funds was more difficult than usual because of a restriction placed on the 1980 energy assistance funds for use beyond June 30, 1980. This restriction, as Assistant Director of the Community Services Administration Michael Blouin told the committee, came from the House of Representatives Appropriations Committee which "conceived of this (program) as a special emergency heating program and was concerned that it not evolve into an indefinite entitlement program." [15]

To resolve this complication and allow funds to be more expeditiously distributed during the summer, several bills were introduced to remove the June 30 prohibition.[16] Immediate action was taken on a measure sponsored by Senators Bentsen, Chiles, and Domenici (S. 2995), which allowed the CSA to obligate funds beyond the June 30 deadline and transfer funds from other programs. This measure was signed by the President immediately (Public Law 96–321), giving more flexibility to agencies and States to serve the needs of heat wave victims.

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[14] Ibid., p. 29.
[15] Ibid. p. 48.
[16] S. 2966, S. 2968, S. 2978, and S. 2995.

Chapter 6

SOCIAL SERVICES

CHAPTER HIGHLIGHTS

In the 15 years since the enactment of the Older Americans Act of 1965, the overall goal of the act—making services available in communities throughout the 57 States and Territories—has been achieved. Therefore, the focus of the 1978 amendments was management efficiency, both fiscal and programmatic.

The amendments, requiring major changes in the national network on aging, provided a 2-year transition period—fiscal years 1979 and 1980. The transition was accomplished in two phases: The promulgation of regulations to implement both title III, State and community programs, and title VI, direct funding for Indian tribal organizations, was completed in phase 1. Implementation of the regulations requiring multiyear State and area plans, mechanisms for providing services and resolving complaints in long-term care facilities and the transfer of payment for community-based supportive services from nutrition funding to social services funding, etc., comprised the second phase.

A multiyear strategy for discretionary programs, title IV, was developed by the Administration on Aging (AoA) in 1978. Since that time, discretionary activities have focused on the following four categories:

—The social integration of older people through policy development and advocacy.

—Serving those in need.

—Long-term care; and

—Improving capacity through application of knowledge.

This multiyear strategy for discretionary programs was the AoA's response to the demographic changes brought about by declining birth rates, extended longevity, changing role of families, and increasing demands for a wider range of community-based services.

Fiscal year 1980–81 appropriations provided modest increases for OAA programs. Additional funding was necessary for States to comply with the expanded mandates of the 1978 amendments. These mandates included direct grants to Indian tribes, federally funded home-delivered nutritional services, State-administered long-term care ombudsman programs and the consolidation of nutrition and social services under one title.

ACTION's established older Americans volunteer programs—foster grandparent, senior companion, and retired senior volunteer programs—saw modest growth in the 1980–81 period. These programs serve the dual purpose of combining the talents and experience of older persons with unmet community and individual needs. Special emphasis is placed on serving the ill, the isolated elderly, and youth who are emotionally or physically disabled.

Congress authorized ACTION to design two new programs to benefit the elderly during fiscal year 1981—fixed income consumer counseling, and helping hand. Although these programs are responsive to persons of every age, the majority of persons helped by both programs are the elderly.

Following 6 years of a congressionally imposed ceiling of $2.5 billion for social services under title XX of the Social Security Act, Congress passed a 1-year only increase in the ceiling in 1978 and authorized future growth by indexing the ceiling with the Consumer Price Index for the next 6 years.

As a result of this legislation, Federal matching grants to States were authorized at $2.7 billion in fiscal year 1980 and $2.9 billion in fiscal year 1981. Services most frequently offered through title XX State plans include day care, homemaker, counseling, and protective services.

The 1978 reauthorization of the Comprehensive Employment and Training Act of 1973 (CETA) provided a greater focus on the employment problems of older workers. The Secretary of Labor was directed to insure that prime sponsors' plans contain procedures for making services available to individuals who are experiencing handicaps in obtaining employment, including those who are 55 years of age and older. Despite the mandates of the CETA legislation, and the assertions by the Department of Labor (DOL) that persons of all working age groups participate in activities under CETA, Congress continues to express concern that the CETA program has not been responsive to the needs of older workers.

Debate over the accessibility of mainline bus and rail systems to the handicapped was rekindled in 1980. Separate measures that would have authorized transit authorities to submit a plan to the Department of Transportation for meeting the needs of the handicapped through specialized transportation services were approved by both the House and Senate. However, in the final days of the 96th Congress, when a compromise could not be reached to reconcile the differences between the two Houses, both measures died.

I. THE OLDER AMERICANS ACT

A. Overview

The Older Americans Act (Public Law 89–73) was first enacted by the 89th Congress in 1965 and amended in 1967, 1972, 1973, 1974, 1975, 1977, and most recently in 1978.

Several major objectives were stated by Congress when the act was passed in 1965:

—The formulation of an Administration on Aging to act and speak on behalf of older persons at the Federal level.

—The development of community-based programs to deliver vitally needed social services to help older persons live independently in their own homes.

—The operation of research and demonstration programs to test innovative ideas; and

—The availability of training grants to provide skilled personnel as programs on aging increased in scope and number.

Although Congress has amended the 1965 act a number of times, it is clear that the major objectives of the act have never changed and that revisions are intended to strengthen and clarify the original intent of the act.

From 1965 to 1972, the Older Americans Act (OAA) was a fledgling program, struggling in most States and communities to obtain local matching funds in order to utilize the Federal funds available to develop programs for older persons. The OAA program began in 1965 with an initial appropriation of $6 million and grew to $33 million in 1971.

The big gain for the OAA, and possibly the action which saved it from an administration movement to abolish it, was the 1971 White House Conference on Aging. The 1971 Conference brought forth a host of recommendations. The one which drew the most attention, from both the White House and the Congress, was a recommendation to fund a national nutrition program. The nutrition program was to be patterned along the lines of 31 demonstration projects which had tested a variety of approaches for nutrition programs for the elderly. These demonstrations had been funded in the late 1960's under the research and demonstration authority of the act.

The nutrition program, enacted in 1972 as title VII of the act (Public Law 92–258), received an appropriation of $100 million for fiscal year 1973. With this new, and visible program, and a total fiscal year 1973 budget of $253 million, the OAA was legitimized as a major piece of social legislation. Consequently, both elected officials and service providers began to examine the legislation and to compete for funding under the act.

The 1973 Older Americans Comprehensive Services Amendments (Public Law 93–92) authorized a major restructuring of the act. These amendments introduced a new concept by mandating the establishment of a nationwide network of substate or area agencies on aging. The objective of the area agency concept was to provide for a better organizational structure at the State and substate levels, and to provide better planning and coordination of resources at the substate or local levels.

The 1973 amendments required States to divide the State into separate areas, "planning and services areas" (PSA's), for the purpose of developing a plan for the establishment of a comprehensive and coordinated system of services to older persons. The State was then required to designate an agency within the PSA as an area agency on aging. This area agency would be responsible for the development and implementation of the comprehensive plan. Although States were urged to designate area agencies, and an incentive was provided for funding of programs under the jurisdiction of area agencies, area agency designation did not become mandatory until the 1978 amendments.

Title V, multipurpose senior centers, also became a part of the act in 1973. This title authorized grants for establishing and operating multipurpose senior centers to serve as a focal point for the delivery of services in each community. Such grants would provide up to 75 percent of the cost of acquiring, altering, or renovating facilities to serve as centers. However, no funds were appropriated for this title until fiscal year 1977 when the first appropriation of $20 million was used to establish or renovate over 500 senior centers.

The 1973 amendments also provided authority for the community service employment programs—title IX. This program provides part-time jobs to low-income individuals aged 55 or over and was modeled after a Department of Labor demonstration program, operation mainstream, which had been funded in 1965 under the Economic Opportunity Act. In the 1978 reauthorization of the OAA, the community services employment program for older Americans became title V, the formula for allocating funds was changed, and the Department of Labor was instructed to use its coordination authority to insure that an orderly placement of job slots be realized within each State.

A minor change in the 1973 amendments combined the separate research and training authority titles of the act into a single title, title IV. Congress took this action to reflect the close interrelationship of training and research and development, and to reemphasize the importance of utilizing the limited funds allocated to this title for the ultimate benefit of future service programs.

This brief overview of the history and development of the OAA provides a basis on which to evaluate and understand the scope of change required by the 1978 amendments, the reasons why Congress considered those changes necessary, and the time period required by State and area agencies to implement fully the changes required by the amendments.

As previously mentioned, no major changes were made in the act from 1973 to 1978. During that 5-year period, a network of more than 600 area agencies had been developed, approximately 2,500 nutrition sites were serving meals from 1 to 5 days per week, and greater responsibilities and roles had been mandated for both the State agencies on aging and the AoA. Congress became increasingly concerned about problems involved in administering the programs, including the fragmentation of programs and services which were intended to serve all older persons; the not infrequent inability of the AoA to manage effectively the Federal appropriations provided for the AoA, and problems with effective coordination of AoA with other Federal agencies providing varied services to older persons. The OAA was considered to be a federally funded, State-administered and locally operated program. However, the employment program, title V, was implemented by the Department of Labor with little or no coordination with the AoA or the national network on aging. The multipurpose senior center funding was directed through the State offices on aging rather than the area agencies, as was the procedure for other title III funding. In many States, the nutrition program was funded directly from the State offices on aging to a multitude of nutrition projects. Priorities for services were being established by Congress rather than being based on needs assessments by local service providers.

Upon careful examination of the demands and responsibilities placed upon the AoA, and the State and area agencies by the various modifications to the original legislation, the 95th Congress determined that the overall goal of making services available in every community throughout the 57 States and Territories had been achieved, that it was time to consolidate various components of the program in the interest of more effective and efficient management. The focus of the 1978 amendments was efficiency in management, both programmatic and fiscal. Seeking to avoid further fragmentation, Congress took action to consolidate existing services and stressed throughout the amendments that there should be a greater degree of coordination among programs serving older people administered by other Federal, State, or local agencies.

A review of the major changes affected by the 1978 amendments may be appropriate at this juncture before examining how the AoA has implemented the changes or the accomplishments and benefits derived from the legislative changes. The significant changes required by the 1978 amendments include the following:

1. COORDINATION

The AoA was given additional responsibilities for coordinating non-Older Americans Act programs affecting the elderly.

2. ADVOCACY

The AoA, along with State and area agencies, was provided specific advocacy responsibilities. For the first time, the advocacy role was explicit in the 1978 legislative provisions.

Each State must develop a State-administered long-term care ombudsman program.

3. ORGANIZATION AND MANAGEMENT

State and area plans will cover 3-year periods.

State plans will be based on area plans.

Each State must develop an intrastate formula for distributing title III–B and title III–C funds (social service and nutrition funds).

Area agencies are required to provide program planning and management responsibilities for all title III–B and title III–C programs.

4. SERVICES

State agencies were given responsibilities for serving patients in long-term care facilities.

Area agencies were required to spend at least 50 percent of their title III–B allotment on the following priority services:

—Access services, including transportation, information and referral, and outreach.

—Legal services.

—In-home services (homemaker and home health aide, visiting and telephone reassurance, and chore maintenance).

—A separate and expanded authority for home-delivered meals.

5. TARGET OR SPECIAL POPULATIONS

Explicit recognition was given to the need to "provide a continuum of care for the vulnerable elderly" under title III.

State and area agencies were directed to give preference in the delivery of services to the elderly with the "greatest economic or social need."

States were directed to expend additional funds in rural areas, above the amounts expended in fiscal year 1978, unless the requirement was waived by the AoA.

6. NATIVE AMERICANS

Title VI was authorized to provide direct grants to qualified Indian tribal organizations for social and nutritional services to Native Americans age 60 or older.

B. TRANSITION PERIOD FOR 1978 AMENDMENTS

The 1978 amendments authorized a 2-year transition period, fiscal years 1979 and 1980, during which time both the AoA and State agencies could waive certain requirements of the act. However, all provisions of the amendments were to be fully implemented no later than the beginning of fiscal year 1981—October 1, 1980. This transition period actually had two phases: The first year—fiscal year 1979 until March 1980—was utilized by the AoA for the development of final regulations to implement title III; the second year—fiscal year 1980—was the period in which the first multiyear State and area plans were developed and the transfer of funding for supportive services for the nutrition program from title III–C to title III–B was completed.

C. 1980—THE FINAL YEAR OF TRANSITION FOR THE 1978 AMENDMENTS

Although the 1978 amendments to the OAA were signed into law effective October 1, 1978, regulations necessary to implement fully the major provisions of these amendments (title III, grants for State and community programs on aging) were not promulgated by the end of 1979. Considerable concern, which later turned to alarm, was expressed both to the AoA and the Department of Health and Human Services (HHS) regarding the lengthy delay in publication of the OAA regulations. Proposed regulations were published by the AoA on July 31, 1979 (vol. 44, Federal Register, p. 45032). The AoA distributed over 100,000 copies of the proposed regulations, held 11 public hearings, received testimony from more than 400 witnesses and written statements from an additional 1,600 individuals. The Commissioner on Aging was the sole witness at a joint hearing of the Senate Subcommittee on Aging of the Labor and Human Resources Committee and the Special Committee on Aging (October 18, 1979), to explain the delay and to discuss several controversial issues which emerged from the proposed regulations during the mandatory 60-day public comment period.

Senator Lawton Chiles, chairman of the Special Committee on Aging, and Pete V. Domenici, ranking minority member on the committee, formally requested a status report from HHS Secretary

Patricia Roberts Harris and her support and assistance in expediting publication of the final regulations. Staff of the Special Committee on Aging reviewed the hundreds of written responses forwarded to the committee from the national network of aging agencies, along with many of the responses provided directly to the AoA, and determined that there was consensus throughout the aging network as to the areas of concern in the proposed regulations. The Commissioner on Aging, Robert C. Benedict, was questioned at the October 18, 1979, hearing about these issues. Senators attending this hearing expressed grave concern that the AoA was not following congressional intent in the development of the regulations and questioned the differences between the perceptions of Congress, the State, and area agencies and local service providers, versus the views of the AoA on the following issues:

—Single organizational unit (to administer the OAA program at State/substate levels).
—State and area agency resource allocation plan.
—State plans review, and the roles of the State Advisory Council and the A–95 review agency.
—Hearings procedures.
—The types of agencies that may be designated as area agencies.
—Service requirements for multipurpose senior centers.
—The relationship between providers of home-delivered and congregate meals programs.
—The options for determining "greatest economic need," "social need," and "rural area."
—Congressional intent relative to the establishment of community focal points; and
—Redesignation of service areas (PSA's) and area agencies on aging.

When the long-awaited final regulations were published on March 31, 1980 (vol. 45, Federal Register, p. 21126), the controversial issues had been resolved with the exception of the single organizational unit issue. The regulations almost completely removed the administrative requirement for a single organizational unit at the State level by permitting States to request waivers from the Commissioner on Aging. States were also provided authority to grant similar administrative waivers to area agencies.

While this issue was resolved to HHS's satisfaction, there was considerable concern both in Congress and the national aging network, that the position taken by the Commissioner on Aging would weaken the role of both the State and area agencies on aging at a time when they needed guidance to meet increasing demands for service caused by growing numbers of older persons and double-digit inflation.

D. 1980—IMPLEMENTATION OF THE 1978 AMENDMENTS

With the 1978 amendments and the final regulations, the role of State and area agencies had been expanded in the following ways:

—States were required to target social services to those older persons with the greatest economic or social need but not to set specific individual eligibility requirements. Factors such as physical and mental disabilities, language barriers, and cultural or social isolation were to be considered when selecting social service sites.

Economic need was defined as the poverty income level established by the Bureau of the Census.

—Area agencies on aging were allowed to directly fund providers of home-delivered nutrition services rather than solely through congregate nutrition projects, as proposed in the draft regulations.

—The statutory requirement for a comprehensive community-based system of services for older persons was reinforced by the regulations. The States were also required to establish long-term care ombudsman programs to investigate complaints of nursing home and adult care home residents.

—Administrative reforms which would reorganize service delivery and authorize 3-year State and area agency planning cycles was stipulated in the regulations.

—Consolidated authority to administer programs under area agencies on aging was provided in the regulations, along with an expanded role for citizen advisory boards and increased community responsibility for planning and administering all OAA programs.

—Both the law and regulations required area agencies on aging to designate community focal points for the colocation of services for older persons in communities and neighborhoods. The final regulations underscored the statutory requirement that needy elderly receive services by requiring that 50 percent of each area agency's service budget be allocated to provide access services, in-home services, and legal services.

The first 3-year State plans to include all of the requirements contained in both the 1978 amendments and the subsequent regulations, were submitted in mid-1980 and went into effect on October 1, 1980.

E. Title III–B and Title III–C—Changes Continue in 1980

Title III–B of the OAA provides the funding for all community services. These funds flow from the AoA through the national aging network, which consists of 10 regional offices, 57 State and territorial offices on aging, 635 area agencies on aging, 4,204 senior centers, 1,185 nutrition projects with 12,556 different meal sites. Title III funds are distributed to the States by a congressionally mandated formula based on the population of older people in each State. In turn, States allocate service funds to area agencies using an intrastate funding formula, which was mandated by the 1978 amendments.

Title III administrative funds, $22.5 million in fiscal year 1980, support the State agencies to assure proper and efficient management of State plans, fiscal control and accounting procedures, and a process to determine which existing private and public programs meet the needs of the State's older residents.

Title III–B social service funds are used to pay up to 85 percent of the cost of operating and establishing a network of community services and multipurpose senior centers. Area agencies fund the network of community services within their PSA, in accordance with the State approved area plan. These services include activities in four basic categories: Access services, in-home services, community and neighborhood services, and services to residents of care-providing institutions. Access services are defined as outreach, and information and referral services. Homemaker and home health aide, visiting and telephone reassurance, and chore maintenance comprise the in-home services. Legal services, residential repair and renovation, acquisition, alteration, renovation and construction of facilities to serve as multipurpose senior centers, are included in the community and neighborhood services category. Additional services in this category are the services designed to meet the unique needs of older individuals, including the services of an ombudsman to receive, investigate, and act on complaints by older individuals who are residents of long-term care facilities; and services which reduce the risk to residents of such facilities and develop or expand opportunities for alternative living arrangements. Authority to provide services to individuals in long-term facilities was provided in the 1978 amendments. The year of transition, fiscal year 1980, revealed the first developing links between community-based services and service to institutionalized individuals.

Title III–C, the nutrition and home-delivered meals section of the OAA, receives the largest single allocation of financial support ($320 million in fiscal year 1980) and is the most visible, and often, the only component of the OAA known to elected officials and older persons. AoA has struggled for years to make the nutrition program more than a meal program. Funds from this title are awarded by formula grants to each State with an approved State plan to pay up to 90 percent of the cost of establishing and operating nutrition services. These funds are combined with other Federal resources and State and local resources to provide both meals and supportive services at over 12,000 nutrition sites across the Nation.

Most of the nutrition sites provide a variety of services and activities in addition to nutritious meals. These sites are under the leadership of trained personnel. Many older persons themselves are paid employees or volunteers at these sites. Since the nutrition site is often the older person's first contact point with other needed services, the "supportive services" component of the site may offer nutrition education, health screening, transportation, and information about community services and benefits, along with meals and social and recreational activities.

The 1978 amendments provided a separate and expanded authorization for home-delivered meals. The appropriation for the home-delivered nutritional services was $50 million in fiscal year 1980, with statutory authority to transfer funds between the congregate and home-delivered meals programs. The regulations authorize States to transfer 15 percent or less of funds between separate allotments for congregate and home-delivered meals without prior approval from the Commissioner on Aging. The Commissioner's approval is required when a State agency wishes to transfer more than this amount. The Commissioner would approve the State agency's request by approving the State plan or plan amendment. Within the constraints imposed by the State plan, the percentage of nutrition funds to be spent for meals in congregate or home-delivered programs is at the discretion of the project operators. Some projects, particularly those in rural areas, may find that the needs of elderly persons in their PSA can best be met through an expanded home-delivered program.

F. TITLE IV—A MULTIYEAR STRATEGY FOR DISCRETIONARY PROGRAMS

The title IV research, training, and demonstration projects support the basic goals and functions of the Older Americans Act programs. These provisions, articulated in title II of the act, have been aggregated by the AoA into four primary areas of responsibility. These areas, the basis upon which the discretionary programs have been developed since 1978 include: (1) The social integration of older people through policy development and advocacy; (2) serving those in need; (3) long-term care; and (4) improving capacity through application of knowledge.

1. POLICY DEVELOPMENT AND ADVOCACY

The 1981 White House Conference on Aging (WHCOA) scheduled November 30 through December 1, will provide an opportunity for older Americans to help in the formulation of national policies which affect older persons. The Conference is charged with producing a final report which expresses a "comprehensive coherent national policy on aging together with recommendations for implementation of the policy." In support of the discretionary projects goal of social integration of older people through policy development, during 1980 the AoA provided funds for seven Mini-White House Conferences in special areas, 51 State conferences, and four regional WHCOA hearings.

The AoA has also provided a forum for national policy review in areas of national policy significance through national policy review and development conferences. The objectives of these conferences are:

—To review and integrate research findings.
—To review current practice.
—To disseminate knowledge.
—To stimulate best practice replication in the public and private sector; and
—To provide new policy and program options.

Each of the conferences involved the following steps:

—Identification of policy questions and problems.
—Preparation of policy background papers.
—Review and critique by invited experts; and
—Submission of reports and recommendations to AoA.

AoA chose to use these conferences as a vehicle by which a Federal agency can assemble the most knowledgeable individuals in and out of government to examine major social policy problems of immediate and long-range importance. During 1980, the AoA funded 13 such conferences focusing on varied issues to include age discrimination, long-term care, older women, abuse or neglect, and business and industry.

Also in support of the development of policy alternatives, the AoA funded national aging policy centers. The purpose of these centers, the majority of which are based in academic institutions, is to provide interdisciplinary analytic approaches for six policy areas. The areas of concentration and their locations are:

—Income maintenance, Brandeis University.
—Housing and living arrangements, University of Michigan.
—Employment and retirement, University of Southern California.

—Education, leisure, and continuing opportunities for older persons, the National Council on Aging, Washington, D.C.
—Older women, the University of Maryland; and
—Health care for the aging, University of California at San Francisco.

These national aging policy centers have been charged with the responsibility of aggregating and synthesizing both AoA and non-AoA research and demonstration findings for use as follows:

—Introduction of research findings into teaching curricula.
—Defining future research agendas; and
—Incorporation of findings into governmental programs, and examination for policy implications.

The AoA's support for advocacy was an outgrowth of the 1978 amendments which established State and area agencies as advocates for older persons. The OAA also requires that every area agency on aging spend "some funds" under title III for legal services. AoA has implemented its services mandate in part by attempting to meet the legal needs of older persons by counsel and representation in order to protect their rights and assist in obtaining benefits and entitlements. These rights include the rights to public benefits, pensions and other retirement income; rights to employment without age discrimination; rights to housing and health care; rights of institutionalized older persons; and rights to alternatives to institutionalization.

Each State is now mandated to have a State-administered long-term care ombudsman program. The ombudsman program must provide the following services:

—Investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities.
—Monitor the development and implementation of laws, regulations, and policies with respect to long-term care facilities in that State.
—Provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities; and
—Train volunteers and promote the participation of citizen organizations to participate in the ombudsman program.

During 1980, AoA promulgated regulations to implement the advocacy, legal services, and ombudsman programs. The agency also chose to use part of its discretionary resources to implement these requirements. Each State agency received a grant to give priority to developing long-term care ombudsman programs and to improving legal services for the elderly. States were to use these discretionary grants for the following purposes:

—To encourage the interrelationship of the ombudsman and legal services programs and improve their coordination.
—To assure more legal support for the ombudsman program, especially in dealing with the problems of the institutionalized elderly; and
—To encourage the increased use of advocacy by nonlawyers to serve older persons.

Five bilingual advocacy assistance support centers were funded by the AoA to help the States meet their mandate to advocate for older persons, expand legal services, and implement the long-term care ombudsman program. These support centers provide materials, research, and legal counsel to the national aging network. Staff for the centers are experienced lawyers and paralegals who design and deliver materials and train and support all States in their regions. In the fiscal year 1980 work plan and contract to fund this plan, the AoA suggested that the work of the centers should include:

—Holding training conferences for State legal services and ombudsman personnel to provide them assistance in substantive areas such as medicare, food stamps, and age discrimination.

—Helping States design statewide training programs for advocates, and training trainers in each State.

—Providing counseling and materials on service delivery systems, including model contracts, evaluation instruments, and funding proposals; and

—Providing analysis of law reform issues and assistance in pursuing law reform litigation and other remedies for elderly clients in the courts.

The 1978 amendments to the OAA made a change with respect to legal services to the elderly by requiring that legal services be added to priority services for which at least 50 percent of the area agencies' title III–B funds must be spent, and by requiring that no less than $5 million appropriated under section 451 of the act be used directly for legal services or to facilitate the provision of such services. AoA met this mandate in 1980 with the following efforts:

—Grants to State agencies to provide specialized staff to develop and support legal ombudsman services in each area agency in the State.

—Biregional advocacy assistance centers to provide specialized training and technical assistance to each State and area agency legal and ombudsman program; and

—Grants to develop training materials and research materials on areas of law of particular concern to the elderly.

2. SERVING THOSE IN NEED

The second part of AoA's evolving discretionary grants strategy is devoted to the goal of "serving those in need." AoA devoted some fiscal year 1981 resources to this concept and funded projects to accomplish the following:

—Improve community-based services.

—Strengthen family support.

—Reach out to minorities; and

—Address special populations and special problems.

Since older persons are very dependent on the neighborhood and the community for meeting basic needs, AoA undertook several studies to estimate the number and characteristics of special retirement communities, and to examine problems of older people in neighborhoods undergoing revitalization. These studies include an endeavor by the National Council on Aging to develop models for senior centers; projects by the Waxter Center in Baltimore, and the Jamaica Service Center in New York to develop models for providing services for the disabled at senior centers; and the operation of an experimental day care center program for the at-risk elderly by a northern Kentucky agency.

Since older people report problems in securing adequate health care, and area agencies indicate that health care is one of the most frequent requests of older people, AoA funded six research and model projects across the country to promote "self-help wellness" and health promotion for persons over age 75. Two of these studies are charged with examining and improving in-home care in conjunction with an HHS-wide long-term care program: Brandeis University is examining several issues in home care including the effectiveness of care planning, whom providers select, and the cost of services provided; the Benjamin Rose Institute is studying the effects of care giving on families who care for older people in their homes.

The 1978 amendments authorized State and area agencies to use title III-B funds to provide services to older people residing in foster homes, housing facilities, domiciliary care, and nursing homes. AoA, consequently, is supporting a number of efforts to expand the supply, and improve the services available, to older people residing in such facilities. For example, over 1,000 nutrition sites are colocated in public and special housing settings and an effort is underway whereby AoA and the Farmer's Home Administration (FmHA) are developing model congregate housing projects for older persons. FmHA funds are being used to construct the facilities, while AoA funds are used to assist area agencies on aging to support the service components of those facilities. This is a 3-year demonstration project for which FmHA has allocated $10 million in resources and AoA, $2.55 million.

In the area of strengthening family support, AoA has funded five research projects and eight demonstration projects to work directly with the problems associated with assisting the family as the primary care giver. Research is being conducted on older people as self-help care givers, the use of high school students as care givers, measuring intrafamily transfers, and the impact of service providers on family networks.

The eight model projects awarded in this category include a project to develop and disseminate training materials directed at assisting adult children to better care givers. Other projects are designing and testing peer support systems and the use of multidisciplinary teams to strengthen efforts of families and friends as care givers in both urban and rural areas.

During 1980, the AoA made a special effort to improve services to minorities. As described in detail below, title VI of the OAA provides direct grants to Indian tribal organizations to provide social and nutritional services comparable to title III services. The AoA conducted a national competition to permit a limited number of area agencies to implement special affirmative action of programs as part of their emphasis on improved service to minorities. Four area agencies were awarded projects. Successful models derived from this experiment will be used by AoA to improve the performance of all agencies providing services to older people. AoA is also conducting six projects targeted at Hispanics as part of an Office of Human Development Services (OHDS) initiative. A final part of this effort on behalf of minorities is the cooperative agreements between the AoA and the following national minority organizations:

—The National Association for Spanish-Speaking Elderly.

—National Center on Black Aged.
—National Indian Council on Aging; and
—The Pacific/Asian Resource Center on Aging.

These organizations work directly with AoA regional offices to assist State and area agencies to improve services to minority communities. From these projects, and other OAA funded research grants, the AoA hopes to significantly enhance knowledge about minority needs and services.

The AoA has also used its discretionary authority and funding to address a number of special problems and special population groups, to wit:

—Five State or area agencies on aging received awards to demonstrate improved methods for service delivery in rural areas.
—A research grant was provided to the American Foundation for the Blind to study adaptive techniques to compensate for sign sensory impairment, and the foundation will produce a handbook describing their work in this area.
—Funds were awarded to three State and area agencies to develop models for meeting the needs of abused older persons.

Limited funding has been provided to improve services to migrants and refugees, to conduct a demonstration project at the Ohio State School for the Deaf, and to help support a number of community hospice projects for the terminally ill.

3. RURAL-URBAN COST DIFFERENTIAL STUDY

In response to an increasing concern about the cost of providing services to the elderly in rural areas, Senator Pete V. Domenici introduced an amendment to the 1978 Older Americans Act during the 1978 reauthorization process to provide increased funds to rural areas through a weighting of the State allotment formula.

Senator Domenici's amendment was passed by the Senate. The conference committee, however, retained the preexisting formula and inserted a new subparagraph (b) of section 307(a)(2) of the act requiring that each State plan provide assurances that the State agency will spend in each fiscal year, for services to older individuals residing in rural areas, an amount equal to not less than 105 percent of the amount spent for such services in fiscal year 1978. During the deliberations on this amendment, conferees realized that information about the differences in needs and existing services, and the comparability of costs of delivering services in rural and urban areas, was not available. Consequently, the conference committee retained a provision, which became a part of the law, directing the Commissioner on Aging to conduct a study related to the differences in unit costs, service delivery, and access between rural areas and urban areas, and the special needs of the elderly residing in rural areas. The law required submission of the report to the Congress no later than October 18, 1980.

As of March 6, 1980, the Administration on Aging had not started the study. This delay was one of the issues addressed by the committee in a hearing on the "Implementation of the Older Americans Act Amendments of 1978," which was chaired by Senators David Pryor and Pete V. Domenici on March 24, 1980.

Subsequent to this hearing, the AoA developed a plan for three phases of the study and began a more intense search for research proposals to fulfill this mandate. An explanation of the three phases and the status of each follows:

Phase I.—A compilation of existing information about unit costs, rural-urban elderly differences in access and services, and the special needs of the rural elderly. AoA planned to accomplish this portion of the study using its staff with the help of consultants. This in-house collection of existing data had not been transmitted to the Congress as of December 31, 1980.

Phase II.—An evaluation study to analyze existing data on rural-urban elderly differences, and to develop a research design for a major field study involving the collection of original data and new information. Phase II of the study will include a review of the relevant literature, an annotated bibliography, a report on rural-urban differences as revealed by the existing literature, and an analysis of existing data. Another product of phase II will be a research design for the field study to gather new information.

The request for proposal for phase II was not issued until September 1980, and the award made to Econometrics Inc., in late January 1981. A final report on the results of this part of the study is expected to be ready for transmittal to Congress by December 1981.

Phase III.—A comprehensive field study of rural-urban elderly services, using the research design developed in phase II. The AoA had intended to release a request for proposal for this study by April 1981. However, since the study design is to be one of the products of the phase II contract, the initiation of this final phase may be further delayed.

No portion of this mandated study was completed by the legislative deadline, and as of December 30, 1980, the AoA had not submitted a status report to Congress explaining the delay. Furthermore, it appeared unlikely that any substantive findings or results would be available for the deliberation on reauthorization of the Older Americans Act in 1981.

4. LONG-TERM CARE

The third component of AoA's discretionary program is long-term care. This past year has brought a concerted effort on the part of AoA to move the agency and national network on aging toward a continuum of care for the functionally disabled. The 1978 amendments to the OAA strengthened AoA's role with respect to the vulnerable, chronically incapacitated elderly. A new section (422) was added to the legislation entitled "Special Projects in Comprehensive Long-Term Care." This section granted the Commissioner authority to make special grants to support the development of comprehensive coordinated systems of community long-term care for older individuals. The key element in the component is "community," and the AoA is devoting substantial dollars and staff resources to the development of truly "community-based" alternatives for the chronically ill or functionally disabled.

Long-term care, in keeping with the intent of the OAA legislation, has been defined by the AoA as health care, social services, or personal care including supervision, treatment, or minor help with everyday tasks, provided formally or informally on a recurring or continuous basis to functionally impaired individuals. This care is provided in homes or other homelike settings, in the community or in an institutional setting if that is the preference of the client or the medically necessary option.

5. LONG-TERM CARE CENTERS AND FELLOWSHIPS

The AoA determined that current public policies and programs do not provide a reasonably comprehensive and coordinated range of community-based services to individuals in need of long-term care. In an effort to affect these public policies and programs, AoA has funded projects which will begin to build a knowledge-and-practice-base for the future: Long-term care multidisciplinary gerontology centers and geriatric fellowships.

Both the centers and the fellowship programs are expected to expedite the development of staff resources and technology, and also to provide opportunities for basic and applied research in long-term care. The AoA developed these programs in response to the perception that health and medical training and research were oriented to acute problems in an era in which the incidence of chronic illness and functional impairment were rapidly increasing. The determination was made by AoA, in conjunction with experts in the field of long-term care, that a multidisciplinary and interdisciplinary approach was necessary to address properly the problems of chronic illness and functional impairment. This group also agreed that the presence of a Federal effort to establish a basis for multidisciplinary staff development and basic and applied research in the treatment of chronic impairment and functional disabilities was long overdue.

As a result, the multidisciplinary centers were planned with a combined health/social services approach. The centers have a clearly defined relationship both with medical schools and with community-based long-term care service providers. The focus of this program is fourfold:

—To enhance the education and training of medical and social service professionals and paraprofessionals regarding the long-term care needs of the elderly.

—To increase the amount and quality of practice-oriented and policy-relevant research dealing with long-term care problems.

—To facilitate innovation and experimentation in long-term care service delivery in an experimental environment; and

—To disseminate the best practice and knowledge through consultation, technical assistance, continuing education and training, and public information.

The geriatric fellowship program was first funded by the AoA in fiscal year 1979 with six grant awards to support the development of multiyear programs to train 18 future faculty members. These geriatric physicians will become members of medical school faculties for the purpose of training others in geriatric medicine, and supervising and encouraging research and practical experiences related to geriatric care.

A critical part of the AoA's long-term care effort is the national channeling demonstration program which is aimed at testing the extent to which State and local governments and agencies can develop, coordinate, and manage long-term care services. The channeling demonstrations, a departmental initiative which cuts across all offices of the Department of Health and Human Services (HHS), are described more fully in chapter 4 of this report.

6. APPLICATION OF KNOWLEDGE AND PRACTICE

The fourth, and final, component of the AoA's discretionary grants strategy is devoted to improving capacity to serve older persons or the application of knowledge and practice. The capacity, and, conceivably, even the willingness of families, community agencies, State, and area agencies to care for the elderly is affected by the degree of skill and competence of the care givers. Since the AoA is charged with the responsibility to assist policymakers, administrators, and service providers and to provide improved methods for developing and managing services, the agency has committed education, training, and research funds to the development of knowledge through research, aggregating and organizing information for systematic distribution and to preparing users to incorporate knowledge in policy articulation, program implementation, and practice.

One method that the AoA has selected to use in improving capacity to serve older persons is through preservice career development and preparation. Title IV–A training funds are used to support the training of persons who are employed or preparing for employment in the field of aging. The AoA has also indicated a commitment to strengthening the capacity of institutions of higher education to prepare persons for careers in aging and to retrain persons already working with older people. The priorities established in career preparation for 1980 are:

—Policy formulation, planning, and management.

—Case management or services management.

—Administration of services, including health, mental health, legal services, employment guidance and counseling, home care, day care, protective services, and transportation; and

—Administration of services to special populations such as minority groups, the rural elderly, the inner-cities elderly.

7. MINORITY RESEARCH PROGRAM

The minority research associate program was initiated by the AoA in response to the 1978 amendments to the OAA. This program provides support for minority institutions under the career preparation programs. It is also expected to increase the participation of minority scholars in the field of aging research. Five projects have been funded with institutions or organizations in an effort to recruit qualified minority social scientists and to stimulate research activity focused on expansion of knowledge concerning the needs of racial and ethnic minority elderly. These projects include Asian Pacific Americans, blacks, Hispanics, and Native Americans and aim to improve services to meet these groups' needs.

In 1980, the AoA funded 22 continuing education and technical assistance grants and contracts. These projects focus on the entire national network services system and range from the development of model information systems for State and area agencies to the development of curricula on serving minorities. Under this rubric, projects have also been funded in the areas of long-term care, in-home services, senior centers, health promotion, and counseling.

Regional education and training programs (RETP's) were developed in each of the 10 Federal regions during 1980. The goal of this program is to foster, on a regional basis, a coordinated approach to education and training by promoting greater understanding and coordination among higher education institutions, State and area agencies on aging and local service providers. It is AoA's hope that such an approach, over a multiyear developmental period, will result in a more efficient use of the limited education and training funds available both from the OAA and from other sources. Under this program, the RETP's are charged to:

—Convene regular regional conferences to bring together representatives from higher education institutions, State and area agencies and service providers to discuss common problems and opportunities.

—Convene regional research utilization and dissemination conferences around content areas of interest to both academic and practitioners.

—Prepare inventories of all education and training resources available in the region and develop procedures for better utilization of these resources; and

—Act as a regional clearinghouse for gathering and disseminating educational, training, and technical assistance materials.

G. DISASTER RELIEF—A DIFFERENT USE OF DISCRETIONARY FUNDS

The AoA also has authority to use discretionary funds for disaster relief. The Disaster Relief Act of 1974 provides for assistance by the

Federal Government to State and local governments in carrying out their responsibilities to alleviate suffering and damage resulting from major disasters or emergencies such as hurricanes, tornados, snowstorms, fires, etc. The OAA authorizes the AoA to reimburse a State for funds that it makes available to area agencies for delivery of social services during a major disaster. These funds are to be taken from the AoA's title IV discretionary funds. During fiscal year 1980, food, clothing, and shelter were provided to disaster victims in Ohio, Washington, Nebraska, Wisconsin, and Alabama.

H. TITLE V—SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Legal authority and funding for the senior community service employment program (SCSEP) is under title V of the OAA. The program is implemented by the Department of Labor through the Office of National Programs, Older Worker Work Group, Employment and Training Administration. Funds for the SCSEP are awarded to eight national organizations and all State governments which in turn promote the creation of part-time jobs in community service activities for low-income persons over the age of 55.

The 1978 amendments (Public Law 95-478) to the OAA made a number of significant changes in the SCSEP and redesignated title IX of the act as title V. Major changes in the law and the proposed regulations include:

—A requirement for more cooperation among all project sponsors.
—An increase in the private or other unsubsidized placement goal to at least 15 percent.
—A reordering of the priorities for enrollment.
—A State residency requirement.
—An increase in income eligibility level to 125 percent of the poverty guideline.
—A provision to allow project sponsors to establish a time limitation on enrollment with written authorization from the Assistant Secretary.
—A stricter limitation on payment of Federal funds into retirement fund for enrollees; and
—An increase to 75 percent of that share of Federal funds that must be used for wages and fringe benefits for enrollees.

Draft rules to implement this title were published on March 25, 1980 (vol. 45, Federal Register, p. 19530), with public comments on the proposed rulemaking due on or before May 27, 1980. This notice of proposed rulemaking (NPRM) was to revise the rules for the SCSEP which has been in effect since the beginning of the program in 1976. Since that time, funding and participants had grown almost fourfold. The number of grantees in 1980 was nearly 12 times the number in 1976 and grants were available both to units of government and private nonprofit organizations.

The proposed rules were based both on the new requirements from the 1978 amendments and the Department of Labor's (DOL) experience with this program. That experience, as well as the proposed rules, were thoroughly examined by the older worker work group staff of the Employment and Training Administration and a specially formed project sponsors' work group. As a result of this early input, it was DOL's hope that the proposed rules would be acceptable to sponsoring organizations, State governments, and other Federal agencies and older workers; could be immediately used by the implementing agencies; and would require little or no revision before final publication.

Although the mandatory comment period on the NPRM closed in May 1980, as of January 1981, final rules had not been published by DOL. Repeated inquiries from DOL have elicited the same response: "Although the regulations are significant, they are not 'major' and staff resources to finalize the regulations have not been available."

Grants totaling $258.8 million to support 52,250 part-time community service jobs for poor persons age 55 and over were awarded to eight national organizations and all State governments by Secretary of Labor Ray Marshall in early July 1980.

At the time of release, Secretary Marshall indicated that the funds would cover the 12-month period, July 1980 through June 1981, and that the program would operate in every State and territory.

Eight national organizations (headquarters in parentheses) received grants totaling $198.5 million:

—Green Thumb, Inc. (Washington, D.C.), an arm of the National Farmers' Union, $76.7 million.

—National Council on the Aging (Washington, D.C.), $22 million.

—National Council of Senior Citizens (Washington, D.C.), $43.2 million.

—National Retired Teachers Association/American Association of Retired Persons (Washington, D.C.), $32.2 million.

—U.S. Department of Agriculture's Forest Service (Washington, D.C.), $15.4 million.

—National Center on Black Aged (Washington, D.C), $2.4 million.

—National Association Pro Spanish-Speaking Elderly (Los Angeles, Calif.), $2.4 million.

—National Urban League (New York City, N.Y.), $4.2 million.

In addition to the grants to the eight national organizations, $59.8 million was provided to the State and territorial governments to create SCSEP jobs. Seven States chose to assign responsibility for operating their State SCSEP grants to one or more of the eight national organizations. Those States include Alabama, Florida, Kansas, New Hampshire, New Jersey, North Dakota, South Dakota, and Puerto Rico.

SCSEP workers fill part-time jobs at senior citizen centers, schools, hospitals, programs for the handicapped, fire prevention programs, beautification, conservation and restoration projects. The participants must be paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is higher. They receive annual physical examinations, personal and job-related counseling, job training if necessary, and in some cases, placement into regular unsubsidized jobs. Participants may work up to 1,300 hours per year and average 20–25 hours per week.

According to DOL, of all persons working in the program during the 1979–80 program year, 80 percent were over the age of 60, and 65 percent were women. More than 30 percent of the participants are minority group members and about 60 percent have less than a high school education. Approximately 50 percent of the workers are in jobs that provide services to the elderly (nutrition programs, outreach and referral, health and home care, transportation, etc.) ; 48 percent of the participants were in jobs created to provide services to the community at large.

The SCSEP has both an urban and rural focus and three of the eight national sponsors—Green Thumb, the Forest Service, and the National Center on Black Aged—operate primarily in rural areas.

The following tables give a breakdown of dollar allocations by State for each national sponsor and each State, as well as authorized participants levels:

SCSEP FOR 1980-81 PROGRAM YEAR—STATE ALLOCATIONS

Legend: A—Green Thumb, B—NCOA, C—NCSC, D—NRTA/AARP, E—Forest Service, F—NCBA, G—Spanish, H—Urban League

State	A	B	C	D	E	F	G	H	Governor's share
Alabama	$524, 074	$340, 335	$1, 982, 060	0	$258, 989	$467, 042	0	0	$1, 077, 500
Alaska	0	0	0	0	0	0	0	0	1, 072, 000
Arizona	85, 540	1, 474, 051	0	0	395, 311	0	0	0	604, 098
Arkansas	2, 996, 980	0	0	$788, 503	375, 190	0	0	0	725, 327
California	2, 205, 743	3, 549, 902	4, 345, 707	3, 244, 043	1, 946, 780	0	$587, 567	0	4, 421, 258
Colorado	475, 828	0	674, 666	304, 278	391, 926	0	0	0	517, 302
Connecticut	140, 794	0	1, 926, 172	0	9, 196	0	0	$349, 320	673, 518
Delaware	0	0	0	0	0	0	0	0	1, 072, 000
District of Columbia	682, 825	0	495, 461	29, 888	0	0	0	0	278, 826
Florida	3, 021, 706	350, 561	1, 420, 633	4, 544, 821	449, 628	286, 752	291, 177	0	2, 987, 722
Georgia	1, 109, 636	448, 433	0	1, 990, 793	400, 158	0	0	235, 554	1, 218, 426
Guam	0	0	0	0	0	0	0	0	536, 000
Hawaii	0	0	0	0	0	0	0	0	1, 072, 000
Idaho	183, 939	0	0	213, 559	500, 087	0	0	0	278, 475
Illinois	3, 842, 828	0	2, 193, 076	1, 103, 313	195, 379	0	267, 938	297, 709	2, 351, 757
Indiana	3, 226, 539	0	1, 580, 496	332, 514	78, 149	0	0	299, 953	1, 256, 349
Iowa	1, 141, 894	0	558, 779	856, 263	0	0	0	0	773, 064
Kansas	1, 722, 569	0	0	0	0	0	335, 638	0	599, 793
Kentucky	1, 743, 978	808, 975	0	690, 657	331, 011	354, 716	0	0	973, 663
Louisiana	1, 021, 371	413, 301	571, 210	587, 301	336, 869	0	299, 971	0	958, 977
Maine	167, 536	920, 777	0	172, 481	41, 407	0	0	0	338, 799
Maryland	309, 443	0	2, 356, 429	0	0	0	0	0	833, 128
Massachusetts	854, 668	0	3, 376, 265	383, 923	0	0	0	300, 012	1, 461, 132
Michigan	3, 018, 362	0	2, 117, 511	848, 409	431, 028	0	0	0	1, 816, 690
Minnesota	3, 529, 637	0	394, 884	0	562, 436	0	0	458, 831	953, 212
Mississippi	423, 888	0	915, 706	0	643, 687	437, 029	0	0	709, 690

Missouri	3, 204, 548	268, 422	385, 020	810, 266	511, 947	0	0	0	1, 359, 797
Montana	900, 143	0	0	269, 015	182, 792	0	0	0	279, 050
Nebraska	1, 214, 771	0	0	389, 558	25, 286	0	0	0	431, 385
Nevada	188, 538	0	0	544, 903	170, 144	0	0	0	278, 415
New Hampshire	325, 372	0	0	339, 199	179, 374	0	0	0	279, 055
New Jersey	3, 461, 063	1, 278, 079	1, 275, 322	0	0	0	0	349, 266	1, 640, 270
New Mexico	0	0	0	415, 606	507, 149	0	0	0	284, 245
New York	5, 059, 494	3, 669, 381	3, 344, 462	2, 223, 534	0	0	0	423, 235	4, 355, 894
orth Carolina	786, 547	434, 460	1, 586, 329	0	1, 574, 602	423, 234	0	0	1, 448, 828
orth Dakota	1, 099, 006	0	0	168, 777	14, 942	0	0	0	278, 275
hio	2, 529, 781	1, 021, 960	2, 179, 252	2, 375, 227	86, 193	0	0	497, 157	2, 692, 430
klahoma	2, 420, 069	0	0	404, 948	99, 995	0	299, 985	0	834, 003
regon	1, 562, 352	245, 940	0	517, 481	743, 727	0	0	0	617, 500
ennsylvania	4, 820, 245	1, 963, 29	2, 565, 418	1, 128, 924	301, 113	0	0	365, 700	3, 302, 980
uerto Rico	996, 812	0	0	1, 006, 730	102, 287	0	0	0	647, 171
hode Island	0	0	370, 149	708, 096	0	0	0	0	278, 755
uth Carolina	797, 438	248, 073	569, 176	501, 108	275, 913	0	0	0	728, 292
uth Dakota	1, 319, 667	0	0	187, 252	50, 576	0	0	0	278, 505
nnessee	1, 329, 184	479, 923	1, 187, 998	0	474, 606	409, 492	0	0	1, 233, 797
xas	4, 704, 563	1, 490, 776	1, 292, 803	2, 161, 783	126, 435	0	299, 995	0	2, 854, 645
ah	735, 191	0	0	0	577, 354	0	0	0	278, 455
rmont	100, 489	915, 288	0	0	111, 459	0	0	0	278, 764
rgin Islands	0	0	0	0	0	0	0	0	556, 000
ginia	2, 271, 563	499, 644	0	859, 450	379, 138	0	0	299, 990	1, 138, 215
shington	539, 401	0	552, 763	941, 024	608, 645	0	0	0	802, 167
st Virginia	194, 591	1, 139, 872	700, 930	0	315, 993	0	0	0	595, 614
sconsin	3, 227, 535	0	1, 698, 122	0	427, 378	0	0	300, 021	1, 187, 944
oming	486, 384	0	0	172, 331	244, 870	0	0	0	278, 415
erican Samoa	0	0	0	0	0	0	0	0	539, 000
cific Islands	0	0	0	0	0	0	0	0	536, 000
National total	76, 704, 525	21, 962, 773	43, 216, 799	32, 251, 958	15, 439, 149	2, 378, 265	2, 382, 271	4, 176, 748	59, 811, 512

SCSEP FOR 1980-81 PROGRAM YEAR

[Total State-by-State allocations and authorized participant levels]

State	Allocation	Number of participants	State	Allocation	Number of participants
Alabama	$4, 650, 000	941	New Hampshire	1, 123, 000	227
Alaska	1, 072, 000	217	New Jersey	8, 004, 000	1, 619
Arizona	2, 559, 000	518	New Mexico	1, 207, 000	244
Arkansas	4, 386, 000	988	New York	19, 076, 000	3, 858
California	20, 301, 000	4, 106	North Carolina	6, 254, 000	1, 265
Colorado	2, 394, 000	484	North Dakota	1, 561, 000	316
Connecticut	3, 099, 000	627	Ohio	11, 382, 000	2, 302
Delaware	1, 072, 000	217	Oklahoma	4, 059, 000	821
District of Columbia	1, 487, 000	301	Oregon	3, 687, 000	746
Florida	13, 353, 000	2, 701	Pennsylvania	14, 448, 000	2, 922
Georgia	5, 403, 000	1, 093	Puerto Rico	2, 753, 000	557
Guam	536, 000	108	Rhode Island	1, 357, 000	274
Hawaii	1, 072, 000	217	South Carolina	3, 120, 000	631
Idaho	1, 182, 000	239	South Dakota	1, 836, 000	371
Illinois	10, 252, 000	2, 074	Tennessee	5, 115, 000	1, 035
Indiana	6, 774, 000	1, 370	Texas	12, 911, 000	2, 621
Iowa	3, 330, 000	674	Utah	1, 591, 000	321
Kansas	2, 6[illegible]8 000	538	Vermont	1, 406, 000	284
Kentucky	4, 904, 000	992	Virginia	5, 448, 000	1, 102
Louisiana	4, 189, 000	847	Virgin Islands	536, 000	108
Maine	1, 641, 000	332	Washington	3, 444, 000	697
Maryland	3, 499, 000	708	West Virginia	2, 947, 000	596
Massachusetts	6, 376, 000	1, 290	Wisconsin	6, 841, 000	1, 383
Michigan	8, 232, 000	1, 665	Wyoming	1, 182, 000	239
Minnesota	6, 499, 000	1, 315	American Samoa	536, 000	108
Mississippi	3, 130, 000	633	Trust Territory of the Pacific Islands	536, 000	108
Missouri	6, 540, 000	1, 323			
Montana	1, 631, 000	330			
Nebraska	2, 061, 000	417	Total	258, 324, 000	52, 250
Nevada	1, 182, 000	239			

The second continuing resolution, signed into law by President Carter on December 16, 1980 (Public Law 96–536), included an increase of $10 million over the administration's fiscal year 1981 budget request, and $10.2 million over the 1980 funding level for the SCSEP. This increase was provided by the House of Representatives during their deliberations on the Department of Labor and Health and Human Services 1981 appropriations bill (H. Rept. 96–1244).

Since the program is primarily forward-funded, with a program year from July 1 to June 30, the funding increase is expected to expand the program from the current level of 52,250 jobs to 54,200. The fiscal year 1981 appropriations also included an increase of $8.7 million to provide for higher minimum wage costs but this is offset by a reduction of $8.5 million to reflect the fact that 4,750 of these jobs were funded for 17 months in the 1980 appropriations act.

The House committee included language in the bill earmarking 80 percent of the appropriations for national contracts. This language created a discrepancy between the law and the appropriations measure. The 1978 amendments to the OAA directed more job slots to State governments by changing the allocation formula and stipulating that any additional funding in succeeding fiscal years would be allotted at 55 percent for the States and 45 percent for the national organizations.

When voting on the continuing resolutions, the Senate Appropriations Committee did not propose an increase for title V but supported the $10 million added by the House of Representatives.

As of December 31, 1980, confusion surrounding the allocation formula still existed. The matter was referred to DOL's Office of the Solicitor; resolution on the allocation formula is expected early in 1981.

I. TITLE VI—GRANTS TO INDIAN TRIBES FOR SOCIAL AND NUTRITIONAL SERVICES

The 1978 amendments to the Older Americans Act (Public Law 95-478) created title VI, a new direct grant program to Indian tribal organizations for older Indians. The purpose of this title was to promote the delivery of social and nutritional services comparable to those services provided through the State and community programs on aging under title III. Under this new title, tribal organizations would be eligible to apply for direct funding to pay the costs of providing social and nutritional services to Indians aged 60 and older. These funds could also be used for the acquisition, alteration, or renovation of multipurpose senior centers.

The law required the AoA to promulgate regulations to implement this title within 90 days of enactment. However, the AoA did not publish the proposed regulations until December 5, 1979, 13 months after enactment of the law. An additional 7 months passed before final regulations were forthcoming.

During the comment period, the AoA conducted nine public hearings at sites located in seven Federal regions. Approximately 200 representatives of Indian tribes, State and area agencies on aging, and national organizations testified or submitted written comments on the proposed regulations. Throughout the comment period, AoA staff consulted with national organizations and Federal agencies including the National Indian Council on Aging (NICOA), the Administration for Native Americans (ANA), the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA). The final regulations, published on July 18, 1980 (vol. 45, Federal Register, p. 48380), reflected the comments of the various agencies consulted.

Concurrent with the development of the title VI regulations, the AoA was developing regulations for title III, grants for State and community programs on aging. Final regulations for the title III programs were published on March 31, 1980 (vol. 45, Federal Register, p. 21126). Since many of the provisions in title III were incorporated into the final regulations for title VI, the AoA insisted that the mandate to publish title VI regulations 90 days after enactment of the law was impossible and would have resulted in inconsistencies between the two programs. The AoA consequently published the title VI regulations 4 months after issuance of final rules for title III, 18 months later than required by congressional mandate.

The OAA establishes the general relationship between titles III and VI in the statement of purpose for each title. In the statement of purpose for title III, State and area agencies are charged with the responsibility of planning and providing social and nutrition services, including multipurpose senior centers, to help "secure and maintain maximum independence and dignity in a home environment for older individuals." Section 601 of title VI states:

> It is the purpose of the title to promote for Indians the delivery of social services, including nutrition services, that are comparable to services provided under title III.

The AoA analyzed the relationship between the provisions of title III and title VI and determined that the title III objective to assure maximum independence and well-being for all older persons is equally valid for title VI. The unique characteristic of title VI is that it is designed to accomplish these goals for older Indians through direct Federal grants to eligible Indian tribal organizations, rather than through State and area agencies.

While the two titles parallel one another, the AoA was cautious not to extend the parallelism too far. Following the guidance provided by the public hearings, and written comments on the regulations, the AoA recognized the unique cultural differences of the Indian population and the frequent necessity to propose choices for the special cultural needs of older Indians.

Section 604 of the act establishes specific relationships between the service requirements for titles III and VI which includes:

—Full compliance by title VI grantees with certain title III requirements concerning the acquisition, alteration, or renovation of multipurpose senior centers; and

—The provision of nutrition, legal, and ombudsman services under title VI to be delivered or made available "substantially in compliance" with the provisions of title III.

A question arose during the development of the title VI regulations as to the meaning of "substantially in compliance." The AoA chose to interpret this phrase to mean that tribal organizations under title VI need meet only certain essential requirements for service delivery. In those cases in which title III requirements for nutrition, legal, and ombudsman were omitted, the AoA determined that the special nature of services for Indians under title VI made the title III requirements inappropriate or overly burdensome.

The title VI regulations also omitted several of the title III service delivery requirements including the preference for those with greatest economic or social needs and the development of a comprehensive and coordinated service delivery system. The AoA, following congressional intent, drafted regulations which provided considerable flexibility to tribal organizations in administering this new title. These regulations specify only those services which must comply with certain title III service requirements and allow tribes the flexibility to provide other services in the manner best suited to the cultural setting.

Flexibility was also provided in the title VI regulations in three basic service categories: nutrition, legal, and ombudsman services. The major changes from title III consist of:

—The addition of a nutrition requirement that special means be provided which meet the particular health, religious, cultural, and dietary needs of individual older Indians; and

—The inclusion of legal and ombudsman services for the selection of providers with expertise in areas of law affecting older persons and the demonstrated capacity to effectively deliver legal services to older persons.

The final title VI regulations clarified the definition of tribal organization and further explained tribal eligibility and tribal selection by older Indians. The definition of "tribal organization" used in the regulations was taken from the Indian Self-Determination and Education Assistance Act. This definition permits three types of tribal organizations to apply:

—The recognized governing body of a tribe.
—Any legally established organization of Indians which is controlled, sanctioned, or chartered by a governing body; or
—One individual democratically elected by the adult members of the Indian community served by the organization.

Both the act and regulations further provided that an organization may perform services benefiting more than one tribe, with the approval of each tribe to be served.

The law specifies that tribal organization may not receive funds from both titles III and VI for the duration of a grant. Therefore, each Indian tribe was encouraged to decide which type of organization could best serve the older members of the tribe. Since title III social services are not provided to tribal organizations, but rather to individual older persons, the regulations clearly stipulated that a tribal organization providing services under both titles III and VI must take whatever steps necessary to insure that the same individuals do not receive services under both titles. Additionally, if tribal organizations do receive funds under both titles, the funds must be administered in accordance with the applicable provisions of the titles under which those funds are received and costs must be allocated for any shared equipment and facilities.

In fiscal year 1980, an initial allocation of $6 million was provided for title VI. Grantees were required to provide nutrition and legal services, and to insure that information and referral services were readily available. If there is a long-term care facility under the jurisdiction of the tribal organization, then an ombudsman program must be established.

During the early months of 1980, and prior to allocation of the title VI funds, the AoA attempted to contact all federally recognized tribes. Approximately 500 tribes were invited to apply for this direct funding. A total of 86 formal applications were submitted to the AoA. These applications were reviewed by a panel of representatives from agencies with special Indian programs and 85 grants were awarded to tribal organizations representing more than 20,000 older Indians. The awards were made not only for service to elderly Indians, but also to develop the capacity of the grantee organizations to provide service to older Native Americans.

J. OLDER AMERICANS ACT FUNDING

1. FISCAL YEAR 1980 APPROPRIATIONS

Fiscal year 1980 appropriations (Public Law 96–123) for OAA programs provided an increase of $150 million, a 16-percent increase over the 1979 funding level. Additional funding was necessary for States to comply with the expanded mandates of the 1978 amendments. These new mandates include direct grants for Indian tribes, a nutrition program providing federally funded home-delivered meals, and prohibiting the use of nutrition funds for supportive services effective in fiscal year 1981. Highlights of the fiscal year 1980 funding increases include:[1]

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[1] Charts showing appropriations for fiscal years 1980–81 and fiscal years 1966–81 are on a later page.

- —Title III–B, social services: A $50-million increase to maintain social services at the 1979 level, to provide transportation services, senior centers, and other supportive activities to the nutrition program, and to begin to compensate for the fiscal year 1981 prohibition on the use of nutrition funds for supportive activities.
- —Title V, community service employment: A $57-million increase to expand job slots from 47,500 to 52,250 for the period from July 1, 1980, through June 30, 1981, and to synchronize funding with other OAA programs.
- —Title VI: $6 million in initial funding for grants to Indian tribes to promote the delivery of social services to Indians.

Fiscal year 1980 funding levels

	Funding levels (in millions)
Title II:	
National Clearinghouse	$2.00
Federal Council on Aging	.45
Title III:	
State administration	22.50
Social services	246.97
Congregate meals	270.00
Home-delivered meals	50.00
Title IV:	
Training	17.00
Research	8.50
Multidisciplinary centers	3.80
Special projects (including long-term care and legal services)	20.50
Title V: Community service employment[1]	266.90
Title VI: Direct grants to Indian tribes	6.00
Total	914.62

[1] Title V is administered by the Department of Labor (DOL) with a program year from July 1979 through June 1980.

2. FISCAL YEAR 1981 APPROPRIATIONS

Fiscal year 1981 funding for OAA programs will be provided under the authority of continuing resolutions until June 5, 1981. The House of Representatives passed its fiscal year 1981 Labor, Health and Human Services appropriations measure (H.R. 7998) on August 27, 1980. The Senate Appropriations Committee did not report a fiscal year 1981 appropriations bill. Therefore, a continuing resolution to guarantee Federal funding for a number of Federal agencies and programs was required.

The first continuing resolution, signed into law on October 1, 1980, provided funding until December 15, 1980 (Public Law 96–369). Since the Senate still had a number of appropriations measures pending on December 15, a second continuing resolution was necessary before the 96th Congress adjourned. The second resolution, signed into law on December 16, 1980 (Public Law 96–536), provides funding through June 5, 1981.

The House Appropriations Committee reported H.R. 7998 on August 21 (H. Rept. 96–1244). The committee's version recommended the following program increases:

- —Title III–B, social services and centers: A $10-million increase to defray costs of support services transferred from nutrition to social services.

- —Title III–C, nutrition: A $30-million increase to cover the increased cost of meals served and to provide expansion in the number of meals served.
- —Title V, senior community service employment: An increase of $10.2 million to expand the program from the current level of 52,250 jobs to 54,200 and to provide for higher minimum wage costs.

Since the Senate Appropriations Committee did not report its version of the fiscal year 1981 appropriations for Labor, Health and Human Services, committee members found it necessary to present an amendment to the House version during the conference on the continuing appropriations measure for fiscal year 1981. During conference deliberations, Senator Lawton Chiles introduced an amendment to provide funding for the following OAA programs:

- —Title III–B, social services and centers: $280 million, an increase of $33 million over the House version to protect community services against inflation.
- —Title IV, research, training and special projects: $38.1, a $7.4-million reduction over the House proposal to highlight the inadequate information provided to Congress regarding the use of the Commissioner's discretionary funds; and
- —White House Conference on Aging: $3 million, the same as the House-passed version (inadvertently omitted from the House continuing appropriations measure H.J. Res. 610) for a total of $6 million for the Conference.

The conferees agreed to a $30-million increase for title III community services during its deliberations on the continuing resolution. This increase was dropped however, when the dispute over Federal pay caused the House to pass a "stripped-down" resolution with most Senate amendments deleted. The House version, which became law on December 16, 1980, retained the $45.5 funding level for title IV and provided continuing funding authority at the $3 million level for the White House Conference on Aging.

Further continuing resolution funding levels, fiscal year 1981

	Funding level (in millions)
Title II:	
National Clearinghouse	$2.000
Federal Council on Aging	.581
Title III:	
State agency administration	22.675
Social services and senior centers	257.000
Congregate meals	296.000
Home-delivered meals	55.000
Title IV:	
Training	14.000
Research	6.000
Gerontology centers	3.000
Special projects (including long-term care and legal services)	22.500
Title V: Senior community service employment [1]	277.100
Title VI: Direct grants to Indian tribes	6.000
Total	960.856

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[1] Title V is administered by the Department of Labor (DOL) with a program year from July 1980 through June 1981.

OLDER AMERICANS ACT APPROPRIATIONS, FISCAL YEARS 1966-80

[In thousands of dollars]

	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Title II:[1]																
National Information and Resource Clearinghouse	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	None	None	2,000	2,000	2,000	2,000
Federal Council on the Aging	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	0.575	0.575	0.575	.450	.450	.450	.581
Title III:																
Area planning[3] and social services	5,000	6,000	10,550	16,000	9,000	9,000	30,000	68,000	68,000	82,000	93,000	122,000	193,000	196,970	246,970	257,000
State agency activities[3]	None	None	None	None	4,000	4,000	5,000	12,000	12,000	15,000	17,035	17,000	19,000	22,500	22,500	22,675
Multipurpose senior centers	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	None	[4] 20,000	[4] 40,000	(5)	(5)	(2)
Nutrition program	(2)	(2)	(2)	(2)	(2)	(2)	(2)	100,000	104,800	125,000	[6] 125,000	[6] 203,525	250,000	277,046	320,000	350,000
Title IV:																
Training	.500	1,403	2,245	2,845	2,610	1,000	8,000	8,000	10,000	8,000	10,000	14,200	17,000	17,000	17,000	14,000
Research	1,000	1,507	4,155	4,185	3,250	2,800	9,000	9,000	7,000	7,000	8,000	8,500	8,500	8,500	8,500	6,000
Model projects, special projects	(2)	(2)	(2)	(2)	None	None	9,700	16,000	16,000	8,000	13,800	12,000	15,000	15,000	25,000	22,500
Mortgage insurance and interest subsidies for senior centers	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	None	[4] None	None	None	None	None
Multidisciplinary centers of gerontology	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	1,000	3,800	3,800	3,800	3,800	3,000
Title V: Community service employment for older Americans[7]	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	10,000	42,000	55,900	90,600	200,900	200,900	266,900	277,100
Title VI: Grants for Indian tribes	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	6,000	6,000
Foster Grandparent program	(8)	(8)	(8)	8,968	9,250	10,000	25,000	25,000	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
Retired senior volunteer program	(2)	(2)	(2)	(2)	None	.500	15,000	15,000	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
Total	6,500	8,910	16,950	31,998	28,110	27,300	101,700	253,000	227,800	287,575	324,310	492,200	749,650	744,166	919,120	960,856

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[1] The title numbers are based on the 1978 amendments.

[2] Not authorized.

[3] Between 1965 and 1970, title III funds were allocated to States for social services. There was no appropriation for State or area planning activities. Beginning in 1970 funds were appropriated for statewide planning. In 1973 funds were appropriated for area planning and social services.

[4] The appropriation covered grants, mortgage insurance and annual interest subsidies, but funds were allocated for grants only.

[5] Multipurpose senior centers are funded under the title III area planning and social services appropriation.

[6] Congressionally mandated operating levels made possible through forward funding were $150,000,000 for fiscal year 1975 and $187,500,000 for fiscal year 1976. Program operating level for fiscal year 1977 was $225,000,000.

[7] Funding is available on an annual basis beginning July 1 and ending the following June 30.

[8] The Foster Grandparent program was funded under a general poverty program through the Economic Opportunity Act from 1977 through 1968. This program was given a statutory basis under the Older Americans Act of 1969. In addition, the retired senior volunteer program was created under the 1969 amendments. Legislative authority under the Older Americans Act was repealed in 1973 and both these programs were reauthorized under the Domestic Volunteer Service Act of 1973 (Public Law 93-113).

K. OFFICE OF HUMAN DEVELOPMENT SERVICES—1980 REORGANIZATION

The Office of Human Development Services (OHDS) is the social services arm of the Department of Health and Human Services (HHS) which provides national program direction and services through its components: The Administration on Aging; Children, Youth, and Families; Native Americans; Developmentally Disabled; Public Services (title XX programs); the President's Committee on Mental Retardation; and the work incentive program. Created in 1977, the OHDS was designed to improve coordination and management of the various social service programs funded through the above-mentioned agencies.

On May 18, 1980, Secretary of HHS, Patricia Roberts Harris, pursuant to the authorities vested in that position, issued an executive order authorizing the reorganization of OHDS. The reorganization order, published on May 21 (45 FR 34069), made a number of organizational changes directly affecting the Administration on Aging (AoA).

According to Secretary Harris, the OHDS reorganization was prompted by two principal concerns: The organizational disruption which occurred when several OHDS components were transferred to the newly created Department of Education in May 1980; and the desire of management officials to strengthen the administration and coordination of social service programs by establishing a more efficient organizational structure.

1. HIGHLIGHTS OF THE OHDS REORGANIZATION

One purpose of the May 1980, OHDS reorganization was to provide an organizational placement which would administer title XX as the special revenue-sharing program that it was intended to be, through a structure which permits title XX integration and coordination with other social services programs. The Department had determined that the parallel placement of title XX program unit with other administrations prevented this from occurring. The title XX program, located within the OHDS, represents over half of OHDS's total budget, an estimated $3 billion annual funding level.

Abolishment of the Administration for Public Services

To accomplish the objectives set forth in the OHDS reorganization, the Administration for Public Services (APS) was abolished and a substantial number of its title XX staff subsequently were transferred to various other OHDS program offices to facilitate services coordination, planning, and review. The remaining APS staff, along with the basic financial and training components of the title XX program, were transferred to a newly created staff office—the Office of Program Coordination and Review—which is located organizationally under the direct administrative and line authority of the Assistant Secretary.

The Administration on Aging was the beneficiary of approximately 40 out of 100 total title XX program positions. These positions were divided equally between the regional offices and headquarters. A number of these new positions were intended to strengthen AoA's operation of its long-term care, research, and program development units. The OHDS reports that this is the largest increase in personnel that AoA has received since the expansion of the Older Americans Act in 1972.

Concurrent with the transfer of APS positions to the OHDS program administrations, leadership responsibilities were delegated to the respective Commissioners for setting program quality standards, substantive technical assistance, and program compliance monitoring for all OHDS-funded categorical social services (including those services funded by title XX). By eliminating the Administration for Public Services, HHS officials contended that such programs as the Administration on Aging would have a more significant impact on the way title XX is administered, to the benefit of the older population.

Secretary Harris, testifying before the House Select Committee on Aging, July 23, 1980, defended the title XX integration objectives of the reorganization by stating:

> The Commissioner on Aging, for instance, will now provide leadership for all programs addressing the needs of the elderly funded through title XX. The Commissioner's influence over the quality, type, and delivery of services will be significantly increased. For example, AoA staff will now be involved in a joint review of title XX State plans with the Office of Program Coordination and Review staff to insure that the needs of the elderly in the States are considered in the development of the plan. In addition, AoA staff will be asked to provide expertise on elderly issues examined by the other program administrations. This structure should significantly strengthen our program operations.

Title XX State Plan Coordination and Joint Reviews

Pursuant to the mandates of the OHDS reorganization order, the Office of Program Coordination and Review was created at both the central office (Washington, D.C.) and regional office levels.

The Office of Program Coordination and Review (OPCR) in the OHDS central office maintains the residual title XX functions, including training and financial management of the program. Furthermore, this new staff office is responsible for promoting the coordination of social services throughout OHDS; managing special projects affecting OHDS target groups; and providing direction to the OHDS regional offices. The OHDS regional administrators report directly to the Director of OPCR in Washington, D.C.

The mission of the OPCR at the regional level is to function as the administrative vehicle directly responsible for the following: Insuring State compliance with title XX administrative requirements; reviewing the overall human services delivery systems in the States; and coordinating, with the regional program staff, reviews of State plans. This last functional mandate, the joint reviews of State plans, is intended to be the driving force within the OHDS regional offices in fostering a sharing of information about State services and to enforce the development of more consistent, comprehensive policies directed toward enhancing social programs for all OHDS target populations.

Consolidation of Financial Management Functions

Financial management responsibilities of all OHDS programs in the regions have been consolidated under the Office of Fiscal Operations (OFO). While the program administrations retain policy control and allocation authority, this office is responsible for fiscal monitoring of all OHDS grantees.

The benefits of a consolidated financial staff were described in written correspondence from Secretary Harris to Congressman Charles Grassley (May 13, 1980). Secretary Harris indicated that the OFO would "eliminate duplicative financial monitoring of those service providers which are grantees under more than one OHDS program."

Prior to the OHDS reorganization order, each regional program office maintained its own separate financial management staff and functional responsibility. Subsequent to the reorganization, all AoA regional financial management officers were transferred to, and their functions consolidated under, the new regional Office of Fiscal Operations. The Administration on Aging, therefore, forfeited direct administrative, financial authority over a total of 13 financial management positions throughout the regions.

Department officials anticipated that a financial management core staff would maintain the knowledge of all OHDS statutory and administrative financial requirements and, as a result, would serve as a single, comprehensive source of expertise concerning service requirements and technical assistance to State and local agencies.

2. AGING CONSTITUENCY REBUTTAL; CONGRESSIONAL CONCERN

In the weeks preceding its official enactment, consideration of the OHDS reorganization order evoked considerable concern among various Members of Congress and aging organizations. This concern was based on the belief that implementation of the OHDS reorganization, as proposed, would not necessarily serve in the best interests of the social service needs of the elderly nor significantly enhance the administration of the Older Americans Act programs.

Congressional opposition to the reorganization was initiated by members of the Senate Special Committee on Aging and House Select Committee on Aging. Specific issues of concern, as well as questions challenging the intent and legality of the reorganization included:

—Statutory authority of the Secretary to reorganize OHDS.

—Loss of fiscal responsibilities and corresponding financial management staff positions from AoA regional program offices.

—Failure to enhance the visibility of the Administration on Aging; and

—Organizational placement and distribution of 40 positions allocated to AoA.

The Department of Health and Human Services (HHS) was also cited for its failure to notify Congress and national aging organizations in advance. Early notification would have facilitated a more thorough review and analysis of, and involvement in the formulation and final decisionmaking regarding implementation of the OHDS reorganization.

As a result, formal requests were submitted to Secretary Harris urging a 60-day postponement of the reorganization—a time period intended to permit full assessment of its impact on the Administration on Aging and other OHDS components. The requested delay in the OHDS reorganization was petitioned for by a significant number of congressional members and aging groups including: Senators John Heinz, Pete Domenici, William Cohen, Charles Percy, and Nancy Kassebaum from the Senate Special Committee on Aging; and the unified backing of 12 national aging memberships, provider, and professional organizations.

Chronology of Events

On April 24, 1980, DHHS officials formally notified Members of Congress and, in particular, the Senate and House Committees on Aging, of the Department's desire to implement the OHDS reorganization order. Meetings between congressional aging committee staff and the OHDS Deputy Assistant Secretary were held to inform and clarify both the organizational and programmatic changes proposed in the reorganization plan. Although they questioned in particular the Secretary's authority to reorganize OHDS, the committees also had other important concerns with regard to the growth of the OHDS as a staff office—a layer of the bureaucracy. Such concerns included the possibility of setting a precedent for absorbing OHDS program components into the central office operation; and that the authority and organizational stature of AoA would be diminished and AoA responsibilities would be delegated to offices beyond the control of the Commissioner. An example of this was the removal of certain fiscal responsibilities from AoA at the regional level. The Members of Congress and national aging organizations objected to the transfer of 13 AoA regional financial management staff to the newly created Office of Fiscal Operations because they felt that the views of State and local administrators involved in providing services under the Older Americans Act should have been solicited to determine the impact of the proposed action on services.

On May 2, 1980, Senator Pete V. Domenici wrote to Secretary Harris requesting a delay in the reorganization. On the same day, 12 national aging organizations made a similar plea. This quickly was followed on May 8, with a letter from several Senators reinforcing this request.

In a written response (May 13, 1980) to Congressman Charles Grassley, ranking minority member of the House Select Committee on Aging, Secretary Harris defended her authority to reorganize by stating:

> The authority (to reorganize) is contained in the Reorganization Plan No. 1 of 1953, which created the Department of Health, Education, and Welfare. Section 1 of the reorganization plan provides that the Department shall be administered under the supervision and direction of the Secretary. Section 6 provides that the Secretary may make such provisions as she deems appropriate authorizing the performance of the functions of the Secretary by any other officer, agency, or employee of the Department. Thus, the Secretary has the authority to organize the functions and offices of the Depart-

> ment as she deems appropriate. Under the Department of Education Organizational Act (Public Law 96–88), the Department of Health and Human Services and its Secretary are successors to the Department of Health, Education, and Welfare and its Secretary, with secretarial authority under the reorganization plan unchanged.

Secretary Harris also assured Congressman Grassley, and members of the House Select Committee on Aging, that the Department "carefully reviewed the Older Americans Act and determined that the organizational changes to be made do not in any way conflict with the requirements of that act."

Despite this reassurance, the widespread opposition to the pending OHDS reorganization expressed by several national aging organizations prompted the Department to convene a meeting with the Secretary and representatives from the organizations to discuss the perceived adverse impact of the reorganization upon the program management responsibilities of the Administration on Aging. During their meeting on May 14, 1980, with the national aging representatives, Secretary Harris responded to the group by reaffirming her position as follows:

—That any delay in implementation of the plan would result in unnecessary hardships for many OHDS employees, since the reorganization was to become effective simultaneously with the transfer of the education components from HEW to the new Department of Education.

—That the reorganization would allow the consolidation of OHDS's limited financial management, thereby improving monitoring and assistance to grantees.

—That the reorganization would create the potential for efficient oversight of Federal outlays through economies of scale and new management systems.

—That the reorganization would create a vehicle for better coordination among the various program units; and

—That the reorganization would open the policy development process to program units.

The Secretary did agree to one concession requested by the group. This concession was to change the name of the Office of Program Integration and Review (OPIR) to the Office of Program Coordination and Review (OPCR) as a first step toward insuring that program units would retain autonomy and programmatic control. She concluded the meeting with an invitation to the group to return in 6 months for a review and evaluation of the reorganization.

Despite the numerous requests for reconsideration, on May 18, Secretary Harris issued the executive order authorizing the reorganization. On May 21, HHS published the announcement in the Federal Register.

On July 7, 1980, the Senate Special Committee on Aging, concerned in general with the legality of the OHDS organizational structure, requested the General Accounting Office (GAO) to conduct a preliminary survey of the structure, and to prepare a legal opinion with respect to the Administration on Aging and the Older Americans Act. Among the various issues to be addressed, the committee specifically instructed GAO's General Counsel to determine if the delegation of legislatively authorized functions of the Commissioner on Aging to other OHDS offices not directly responsible to the Commissioner is legal and consistent with statutory intent.

Members of the Senate Special Committee on Aging had previously expressed concern about the organizational placement of AoA in the Department of Health and Human Services. During the Senate hearing on the confirmation of Cesar A. Perales, as Assistant Secretary of the Office of Human Development Services, Senator John Heinz posed the following questions: Whether AoA functions were being assigned to offices beyond the control of the Commissioner on Aging; whether the Commissioner was required to report directly to the Secretary; and whether staff positions initially designated for the AoA to administer the OAA were diverted to OHDS officers.

Assistant Secretary Perales responded on the day of the hearing, and also in a subsequently written response to Senator Heinz, that it was not the intent of the Department to circumvent the provision of section 201 of the Older Americans Act with respect to the authority of the Commissioner on Aging, and that all staff slots currently assigned to AoA were filled by persons reporting directly to the Commissioner.

On August 14, 1980, Milton Socolar, GAO General Counsel, responded to the committee's request for an opinion. The GAO opinion stated:

> A delegation of functions of the Commissioner to the OHDS officials not directly responsible to the Commissioner would violate the restriction in 42 U.S.C. 3011(a).

The opinion went on to explain that this delegation of functions did not have to be through a formal mechanism:

> Functions may be delegated in a formal or informal manner. Formal delegations may be made, for example, through a statement of mission, organization, function, and delegation of authority which is published in the Federal Register. On the other hand, informal delegations may be made by verbal orders, by office memoranda, or by custom and usage. In order to determine whether a function has been informally delegated, a determination must be made on a case-by-case basis.

The report also stated that while the location of AoA within OHDS was consistent with the requirement for the Commissioner to report directly to the Secretary, the Congress also intended the Commissioner to have "the requisite authority and responsibility to implement the important mission of the AoA." Furthermore, "Congress did not intend that the Commissioner should be required to deal with intermediate level officials in OHDS."

Although the GAO's legal interpretation was made subsequent to the May 18, 1980, OHDS reorganization order, it supported the concern of the national aging organizations regarding the authority of the Secretary to transfer AoA regional staff to an OHDS staff office which is outside the direct reporting purview of the AoA Commissioner. In this regard, the GAO made the following statement:

> Because AoA is a statutory agency and the Commissioner is by law the agency head, AoA regional staff are directly responsible to the Commissioner. The work of the AoA re-

> gional staff is assigned and supervised by officials subordinate to the Commissioner. On the other hand, the OHDS Regional Administrator is responsible for coordinating OHDS programs for a specific area. Therefore, AoA regional staff may be required to coordinate their activities with the OHDS Regional Administrator.

A similar analysis was provided by the American Law Division of the Congressional Research Service to the House Select Committee on Aging. The CRS took the position that the law and congressional intent clearly prohibited the delegation of any functions, including policymaking and routine administrative services, to any officer not directly responsible to the Commissioner.

While the legal opinion supported the Secretary's authority to reorganize, concerns relative to the delegation of authority and the organizational placement of the AoA remained. These issues will, no doubt, receive careful scrutiny during the 1981 reauthorization of the OAA.

II. ACTION'S OLDER AMERICANS VOLUNTEER PROGRAMS

The three established older Americans volunteer programs—the senior companion program (SCP), the retired senior volunteer program (RSVP), and the foster grandparent program (FGP), saw modest growth in the 1980–81 period.

Two relatively new ACTION programs, relevant to older Americans, which saw more substantial expansion are the fixed income consumer counseling (FICC) and helping hand (HH).

The ACTION agency's older Americans volunteer programs (OAVP) are authorized under title II of the Domestic Volunteer Service Act of 1973 (Public Law 93–113). The most recent amendments to that act, included in the Comprehensive Older Americans Act Amendments of 1978 (Public Law 95–478), reauthorized the programs through fiscal year 1981. These programs serve the dual purpose of combining the talents and experience of older persons with unmet community and individual needs. Special emphasis is placed on serving the ill, the infirm, the isolated elderly, and youth who are emotionally, mentally, or physically disabled.

Categorical project grants are awarded by ACTION to private nonprofit organizations, and public agencies which recruit, place, and support volunteers. The volunteer services are, in turn, provided through public and private nonprofit agencies and proprietary health care facilities. The OAVP projects are locally sponsored and locally administered with basic program decisions made at the community or neighborhood level. Within the context of the legislation, volunteer activities derive from agreements among the volunteer project staff, and the community as represented by volunteer stations, advisory councils, and the volunteers themselves.

A. Retired Senior Volunteer Program

The retired senior volunteer program (RSVP) was established in 1971 to provide persons age 60 and over with opportunities for volunteer service in their own communities. The RSVP volunteers serve more than 4 hours per week on the average, counseling other citizens in health and nutrition, consumer concerns, crime and victimization, banking and finance, rebate programs, legal problems, energy conservation, and fixed income expenditure. These older volunteers receive no stipend or wage but may be reimbursed for transportation up to $1.85 per day.

The fiscal year 1980 appropriation for RSVP was $26 million to allow expanded volunteer opportunities for approximately 17,000 older persons in 170 existing projects and to fund 22 new projects, enabling another 7,700 older persons to serve communities.

The RSVP program received a small increase in fiscal year 1981 funding—$1.717 million. The total appropriation of $27,717.000 will provide resources for 272,600 volunteers in 719 programs—707 continuing and 12 new.

B. Foster Grandparents

The foster grandparents program (FGP) used the "grandparent" concept, a social role which can be filled only by an older person. Foster grandparents are low-income people, age 60 and older, who provide supportive person-to-person services to children with exceptional or special needs. Foster grandparents serve 20 hours per week working with children—both in and out of institutions—who have mental, physical, or emotional handicaps. They seek to prevent or delay the institutionalization of children and to deinstitutionalize children who can live in the community when a limited number of services are provided. These grandparents receive a stipend of $2 per hour for their volunteer activities.

The fiscal year 1980 appropriation of $46.9 million allowed 17,000 grandparents to assist over 42,000 children. The fiscal year 1981 appropriation of $48,400,000 will provide resources for 17,877 volunteers in 219 programs—208 continuing and 11 new. These volunteers will assist approximately 54,000 children in all States, the District of Columbia, Puerto Rico, and the Virgin Islands.

C. Senior Companions

The senior companion program (SCP) provides the opportunity for low-income people age 60 and older to provide personal assistance and companionship primarily to other older adults. Senior companions serve 20 hours per week seeking to prevent or delay the institutionalization of the chronically homebound elderly, shorten the stay of those elderly temporarily institutionalized, and deinstitutionalize persons who are able to live at home when some services are provided. The volunteer companions also receive a stipend of $2 per hour for their services.

During fiscal year 1980, 80 percent of the senior companions were over 65 years of age, 46 percent were over 70. 74 percent of the volunteers were widowed or single, and 63 percent lived alone. Of the senior companions, 40 percent were nonwhite. Of those served by the senior companions, 81 percent were age 65 or older, and 50 percent were 75 years old or older. Approximately 60 percent of the clients live alone and 81 percent lived in their own homes.

The fiscal year 1980 appropriation of $10.200,000 provided stipends for 3,820 volunteers in 61 programs—54 continuing and 7 new programs. The fiscal year 1981 appropriation of $12,783,000, an increase of $2,583,000, will provide resources for 4,360 volunteers in 75 programs (62 continuing and 13 new programs).

D. New ACTION Programs

Reauthorization of the Domestic Volunteer Service Act at the end of the first session of the 96th Congress (Public Law 96–143) added two new programs to ACTION designed to benefit the elderly: fixed income consumer counseling and helping hand.

The primary objective of the fixed income consumer counseling (FICC) program is to provide volunteer assistance which will help individuals and families with limited incomes to expand and/or maximize the use of available resources by gaining access to entitlements, organizing citizen responses to common problems, and facilitating coordination of available consumer assistance resources. Although the program is responsive to persons of every age and employment status whose income is near or below the poverty guideline, the majority of persons helped by this program are retired low-income elderly.

Project grants for this new program average $50,000 and are available to communities with a population of 50,000 and which have high concentrations of people on fixed incomes. An average project utilizes 400 volunteers who serve a total of 80,000 hours working directly with 5,000 to 10,000 persons on fixed incomes. Multilingual services are provided through seminars, individual counseling, small group workshops, and literature. The activities take place on an outreach basis in nursing homes, adult care centers, schools, and community centers. The fiscal 1981 appropriation of $381,000 provides resources for 12 project grants. A pending supplemental 1981 appropriation requests an additional $2,589,000 to support an additional 48 project grants.

The helping hand program is part of a long-term demonstration to test the reduction in institutionalization of citizens by providing individual supportive services using volunteers in cooperation with professionals. The program will respond to the functional and psychological needs of deinstitutionalized people including the emotionally, mentally, and physically disabled. Twelve helping hand grants, averaging $50,000 each, will enable State and local institutions to train and support approximately 4,000 part-time volunteers.

E. Future of OAVP

The OAVP's authorizing legislation will expire September 30, 1981. The 97th Congress will be responsible for considering legislation necessary to extend and amend these programs.

III. TITLE XX—SOCIAL SERVICES

Following 6 years of a congressionally imposed ceiling of $2.5 billion for social services under the Social Security Act, Congress passed a 1-year-only increase in the title XX ceiling in 1978 and allowed $2.9 billion for services in fiscal year 1979. The Social Welfare Reform Amendments of 1979, which became law June 17, 1980 (Public Law 96–272), authorized a $200-million spending cut in the program by reducing the ceiling to $2.7 billion for fiscal year 1980.

Although there were cuts in social service spending in 1980, H.R. 3434 did prevent immediate cuts in State programs. Without the authority provided in Public Law 96–272, the title XX limit for 1980 would have reverted to its permanent level of $2.5 billion. That spending level would have required sharp reductions in State social service programs for the remainder of 1980.[2]

The House passed H.R. 3434 on August 2, 1979, and the Senate passed its version on October 29, 1980. Although the bill was approved in a Senate-House conference in April, it could not be considered for final action until after approval of the third budget resolution for fiscal year 1980. That resolution was cleared on June 12, allowing the conference report on H.R. 3434 to be approved in both the House and Senate by voice vote.

ALLOTMENT LIMITATION FISCAL YEAR 1980—FEDERAL ALLOTMENT

State	Social services	Child day care	Total
Alabama	$42, 642, 000	$3, 411, 360	$46, 053, 360
Alaska	4, 703, 000	376, 240	5, 079, 240
Arizona	26, 533, 000	2, 122, 640	28, 655, 640
Arkansas	24, 776, 000	1, 982, 080	26, 758, 080
California	253, 037, 000	20, 242, 960	273, 279, 960
Colorado	30, 266, 000	2, 421, 280	32, 687, 280
Connecticut	35, 917, 000	2, 873, 360	38, 790, 360
Delaware	6, 725, 000	538, 000	7, 263, 000
District of Columbia	7, 974, 000	637, 920	8, 611, 920
Florida	97, 674, 000	7, 813, 920	105, 487, 920
Georgia	58, 336, 000	4, 666, 880	63, 002, 880
Hawaii	10, 343, 000	827, 440	11, 170, 440
Idaho	9, 903, 000	792, 240	10, 695, 240
Illinois	129, 951, 000	10, 396, 080	140, 347, 080
Indiana	61, 595, 000	4, 927, 600	66, 522, 600
Iowa	33, 270, 000	2, 661, 600	35, 931, 600
Kansas	26, 880, 000	2, 150, 400	29, 030, 400
Kentucky	39, 962, 000	3, 196, 960	43, 158, 960
Louisiana	45, 312, 000	3, 624, 960	48, 936, 960
Maine	12, 538, 000	1, 003, 040	13, 541, 040
Maryland	47, 831, 000	3, 826, 480	51, 657, 480
Massachusetts	66, 818, 000	5, 345, 440	72, 163, 440
Michigan	105, 497, 000	8, 439, 760	113, 936, 760
Minnesota	45, 936, 000	3, 674, 880	49, 610, 880
Mississippi	27, 608, 000	2, 208, 640	29, 816, 640
Missouri	55, 482, 000	4, 438, 560	59, 920, 560
Montana	8, 794, 000	703, 520	9, 497, 520
Nebraska	18, 039, 000	1, 443, 120	19, 482, 120
Nevada	7, 315, 000	585, 200	7, 900, 200
New Hampshire	9, 811, 000	784, 880	10, 595, 880
New Jersey	84, 696, 000	6, 775, 680	91, 471, 680
New Mexico	13, 752, 000	1, 100, 160	14, 852, 160
New York	207, 135, 000	16, 570, 800	223, 705, 800
North Carolina	63, 848, 000	5, 107, 840	68, 955, 840
North Dakota	7, 546, 000	603, 680	8, 149, 680
Ohio	123, 654, 000	9, 893, 120	133, 557, 120
Oklahoma	32, 485, 000	2, 598, 800	35, 083, 800
Oregon	27, 458, 000	2, 196, 640	29, 654, 640
Pennsylvania	136, 191, 000	10, 895, 280	147, 086, 280
Rhode Island	10, 805, 000	864, 400	11, 669, 400
South Carolina	33, 236, 000	2, 658, 880	35, 894, 880
South Dakota	7, 962, 000	636, 960	8, 598, 960
Tennessee	49, 680, 000	3, 974, 400	53, 651, 400
Texas	148, 267, 000	11, 861, 360	160, 128, 360
Utah	14, 653, 000	1, 172, 240	15, 825, 240
Vermont	5, 581, 000	446, 480	6, 027, 480
Virginia	59, 341, 000	4, 747, 280	64, 088, 280
Washington	42, 273, 000	3, 381, 840	45, 654, 840
West Virginia	21, 483, 000	1, 718, 640	23, 201, 640
Wisconsin	53, 784, 000	4, 302, 720	58, 086, 720
Wyoming	4, 692, 000	375, 360	5, 067, 360
Total	2, 500, 000, 000	200, 000, 000	2, 700, 000, 000

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[2] Charts showing State title XX allotments for fiscal years 1980 and 1981 are on a later page.

ALLOTMENT LIMITATION FISCAL YEAR 19[illegible]—FEDERAL ALLOTMENT

State	Social services	Child day care	Total
Alabama	$46, 332, 057	$3, 432, 004	$49, 764, 061
Alaska	4, 969, 797	369, 614	5, 359, 411
Arizona	29, 146, 356	2, 158, 989	31, 305, 345
Arkansas	27, 066, 241	2, 004, 907	29, 071, 148
California	276, 036, 044	20, 447, 115	296, 483, 159
Colorado	33, 058, 950	2, 448, 811	35, 507, 761
Connecticut	38, 370, 669	2, 842, 272	41, 212, 941
Delaware	7, 218, 490	534, 703	7, 753, 193
District of Columbia	8, 345, 218	618, 164	8, 963, 382
Florida	106, 407, 722	7, 882, 054	114, 269, 776
Georgia	62, 948, 204	4, 662, 829	67, 611, 033
Hawaii	11, 106, 321	822, 691	11, 929, 012
Idaho	10, 871, 071	805, 264	11, 676, 335
Illinois	139, 206, 659	10, 311, 604	149, 518, 263
Indiana	66, 538, 876	4, 928, 806	71, 467, 682
Iowa	35, 857, 199	2, 656, 088	38, 513, 287
Kansas	29, 072, 066	2, 153, 486	31, 225, 552
Kentucky	43, 310, 939	3, 208, 218	46, 519, 157
Louisiana	49, 105, 542	3, 637, 447	52, 742, 989
Maine	13, 508, 358	1, 000, 619	14, 508, 977
Maryland	51, 297, 090	3, 799, 785	55, 096, 875
Massachusetts	71, 481, 528	5, 295, 668	76, 787, 196
Michigan	113, 774, 792	8, 427, 762	122, 202, 554
Minnesota	49, 625, 570	3, 675, 969	53, 301, 539
Mississippi	29, 765, 437	2, 204, 847	31, 970, 284
Missouri	60, 174, 719	4, 457, 386	64, 632, 105
Montana	9, 719, 579	719, 969	10, 439, 548
Nebraska	19, 377, 250	1, 435, 352	20, 812, 602
Nevada	8, 171, 875	605, 324	8, 777, 199
New Hampshire	10, 784, 400	798, 844	11, 583, 244
New Jersey	90, 720, 198	6, 720, 015	97, 440, 213
New Mexico	15, 006, 535	1, 111, 595	16, 118, 130
New York	219, 749, 157	16, 277, 716	236, 026, 873
North Carolina	69, 052, 346	5, 114, 989	74, 167, 335
North Dakota	8, 072, 822	597, 987	8, 670, 809
Ohio	133, 090, 134	9, 858, 528	142, 548, 662
Oklahoma	35, 659, 093	2, 641, 414	38, 300, 507
Oregon	30, 260, 701	2, 241, 535	32, 502, 236
Pennsylvania	145, 484, 145	10, 776, 603	156, 260, 748
Rhode Island	11, 576, 823	857, 543	12, 434, 366
South Carolina	36, 129, 595	2, 676, 266	38, 805, 861
South Dakota	8, 543, 324	632, 839	9, 176, 163
Tennessee	53, 946, 759	3, 996, 056	57, 942, 815
Texas	161, 134, 524	11, 935, 891	173, 070, 415
Utah	16, 182, 790	1, 198, 725	17, 381, 515
Vermont	6, 029, 853	446, 656	6, 476, 509
Virginia	63, 740, 628	4, 721, 528	68, 462, 156
Washington	46, 728, 269	3, 461, 353	50, 189, 622
West Virginia	23, 029, 831	1, 705, 913	24, 735, 744
Wisconsin	57, 933, 644	4, 291, 381	62, 225, 025
Wyoming	5, 249, 810	388, 876	5, 638, 686
Total	2, 700, 000, 000	200, 000, 000	2, 900, 000, 000

The conference agreement on H.R. 3434 included several complicated compromises between the House position, which called for increased Federal spending, and the Senate position which sought to reduce the level of spending. On one major, costly item—grants to States for social service programs—conferees accepted the Senate's $200 million cut to $2.7 billion for 1980. Federal matching grants to States were authorized at $2.7 billion, compared with the $2.9 billion for fiscal year 1979 and the House position of $3.1 billion for 1980. The final bill did authorize future growth by gradually indexing the ceiling with the Consumer Price Index (CPI) for the next 6 years as follows:

—$2.7 billion in fiscal year 1980.
—$2.9 billion in fiscal year 1981.
—$3 billion in fiscal year 1982.
—$3.1 billion in fiscal year 1983.
—$3.2 billion in fiscal year 1984; and
—$3.3 billion in fiscal year 1985.

The basic title XX program of grants to States supports social services for individuals and families. Legislated service goals include preventing abuse and neglect of children and adults, helping individuals achieve economic self-sufficiency, and preventing inappropriate care in institutions. At least 50 percent of the Federal funds must be used for services to public assistance recipients while the remaining funds may be used for other low-income individuals. Services most frequently offered through title XX State plans include day care, homemaker, counseling, and protective services.

TRAINING

Public Law 96–272 also placed a limitation on Federal matching funds for training and mandated a formula for allocating such limitation. This limitation on training funds was in response to a congressional perception that title XX training expenditures were increasing too rapidly since these training funds were open-ended. For fiscal year 1980, the formula for Federal matching funds, as published on August 27, 1980 (vol. 45, Federal Register, p. 57175) is limited to the highest of:

—Four percent of the State's allotment for title XX social services.

—The actual amount of Federal matching for the amounts spent by the States for training in fiscal year 1979; and

—The amount payable to the State with respect to State appropriations made prior to October 1, 1979, for fiscal year 1980, limited to $6 million distributed proportionally among affected States.

On the basis of the formula alone, the maximum entitlement for personnel training or retraining would be $143,381,730. However, the supplemental appropriations bill for fiscal year 1980 limited the funding to $75 million. The Federal allotment for training to each of the 50 States and the District of Columbia was reduced proportionally as follows:

State:	*Allotment*
Alabama	$963,582
Alaska	109,101
Arizona	1,077,004
Arkansas	1,400,935
California	6,147,747
Colorado	683,921
Connecticut	5,955.672
Delaware	151,965
District of Columbia	234,438
Florida	2,207,142
Georgia	1,443,981
Hawaii	233.721
Idaho	223,779
Illinois	2,936,505
Indiana	1,391,864
Iowa	751,808
Kansas	607,408
Kentucky	1,484,294
Louisiana	1,330,088
Maine	630,220
Maryland	1,060,838
Massachusetts	2,148.729
Michigan	2,383,918

State:	Allotment
Minnesota	1, 088, 017
Mississippi	705, 612
Missouri	1, 253, 728
Montana	616, 368
Nebraska	407, 623
Nevada	169, 775
New Hampshire	221, 690
New Jersey	1, 913, 877
New Mexico	593, 974
New York	7, 915, 891
North Carolina	2, 162, 524
North Dakota	280, 125
Ohio	2, 794, 438
Oklahoma	754, 584
Oregon	620, 469
Pennsylvania	3, 990, 130
Rhode Island	439, 956
South Carolina	751, 094
South Dakota	179, 917
Tennessee	1, 122, 620
Texas	4, 724, 244
Utah	635, 448
Vermont	408, 237
Virginia	1, 547, 102
Washington	1, 235, 407
West Virginia	1, 244, 308
Wisconsin	1, 414, 640
Wyoming	284, 584
Total	75, 000, 000

The passage of H.R. 3434, which necessitated the new reimbursement formula, set limits on Federal matching payments for State training of social service workers for fiscal years 1980 and 1981, required that Federal matching funds be allowed only for State training programs that have been approved by the Department of Health and Human Services (HHS).

IV. TRANSPORTATION—UMTA

A. ACCESSIBILITY ISSUE REKINDLED

Debate over making mainline bus and rail systems accessible was rekindled in 1980, as Congress considered amendments to give local transit systems the option of establishing specialized transportation services to meet the needs of the handicapped.

Separate measures approved by the House and Senate would have authorized transit authorities to submit a plan to the U.S. Department of Transportation for meeting the needs of the handicapped through specialized transportation services (such as vans and minibuses).[3] If a plan met guidelines outlined in the amendments and was approved by the Secretary, the transit authority would be deemed in compliance with Federal accessibility requirements, including section 504 of the Rehabilitation Act of 1973.

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[3] The House Public Works and Transportation Committee adopted a local option amendment offered by Representative James Cleveland to H.R. 6417 on May 14 (H. Rept. 96-963). When considered by the full House, the local option provision was modified before the bill passed the House on December 4. The Senate's local option provision was adopted as an amendment to S. 2720. Offered by Senator Edward Zorinsky, it was approved by the Senate on June 25.

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In the final days of the 96th Congress, a compromise local option provision which reconciled differences between the House and Senate measures died as Congress adjourned before the Senate voted on the compromise.

B. APPROPRIATIONS LEGISLATION

An amendment addressing the accessibility issue was, however, inserted into the 1981 transportation appropriations measure (H.R. 7831).

Before reporting H.R. 7831, the Senate Committee on Appropriations adopted an amendment prohibiting the Department of Transportation from using any of its funds to "compel local transit authorities to purchase wheelchair lifts to comply with section 504 of the Rehabilitation Act of 1973." The amended legislation was reported on September 9.

When the bill was considered by the full Senate on September 18, Senator Robert Dole of Kansas offered an amendment to stipulate that funds could be used to compel transit authorities to purchase wheelchair lifts under the following circumstances:

(1) To the extent required under the Senate version of the aforementioned local option amendment, and

(2) Where transit authorities have elected to purchase lifts.

The provision was retained in the bill that passed Congress, and was signed into law (Public Law 96–400).

Subsequent to the bill's passage. Secretary of the U.S. Department of Transportation Neil Goldschmidt, asked his General Counsel for an opinion on the amendment's implications. The resulting opinion, transmitted on October 27, 1980, clarified the Department's position on the amendments as follows:

> . . . The Department is authorized to use funds under the 1981 Appropriations Act to plan and execute programs to compel the purchase of lifts in accordance with the Department's 504 regulation until a recipient has submitted and the Secretary has approved an alternative transportation program meeting the requirements of the Zorinsky amendment (Senate version of the local option amendment). At that point, the Department would only be authorized to use appropriated funds to compel lifts at the levels provided for in a recipient's approved program. It should be noted, however, that even if the Department approved a recipient's alternative program under the Zorinsky amendment, the recipient would face the risk of a court challenge to any purchases of inaccessible buses. Such a challenge would be based on the argument that section 324 was only intended to limit the expenditure of funds by the Department and did not overturn the Department's 504 regulation.

Chapter 7

HOUSING

CHAPTER HIGHLIGHTS

The cost of owning and maintaining a household continued to climb during 1980. The Consumer Price Index rose approximately 13.5 percent with energy and housing prices posting the greatest increases. Energy prices alone rose 31 percent and housing prices rose 15.7 percent.[1]

Such increases continued to place a significant burden on the elderly to maintain homes and locate alternative housing.

Construction and land costs continued to plague the development of Federal housing programs. Sponsors and developers were faced with cutting back in the design of projects to meet the escalating costs of land and materials.

Although the Congress passed the Housing and Community Development Amendments of 1980 (Public Law 96–399), these amendments did little to change or expand the existing array of housing and subsidy programs. The talk of "housing block grants" by the new administration guarantee a comprehensive scrutiny, at the least, of the housing programs by the 97th Congress.

I. FEDERAL HOUSING PROGRAMS FOR THE ELDERLY

Federal housing programs for the elderly under the Department of Housing and Urban Development (HUD) were afflicted with the problems that all housing programs, public as well as private, experienced during 1980: How to finance, construct, and maintain decent and affordable housing for the low income when faced with today's inflated housing costs. Climbing interest rates put strains on sponsors and continually rising costs placed unprecedented demands on rent subsidy programs such as section 8. The declining availability of rental units in many communities put pressure on everyone, including sponsors, developers, and residents.

As elderly residents continued to seek decent and affordable housing alternatives, demands on Federal housing programs grew. Waiting lists for section 202 projects and congregate housing gave evidence to this demand. More and more elderly occupied units in all forms of public housing as shown by the following HUD listing of housing programs.

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[1] U.S. Department of Labor, Bureau of Labor Statistics.

SUMMARY OF HUD HOUSING UNITS FOR THE ELDERLY

[All figures represent number of projects/units currently insured by FHA unless otherwise noted]

Section No., and program	Status	Number of projects	Number of units	Value	Approximate number of elderly units	Percent of elderly units	Report period
Construction projects:							
Title II: Low-income public housing	Active	10,750	1,200,000	NA	[1] 552,000	46±	Cumulative through Sept. 30, 1979.
202: Direct loans for housing for elderly and handicapped	Inactive [2]	330+	45,275	574,580,000	45,275	100	Cumulative through 1972.
	Active [3]	1,211	91,716	3,325,074,000	87,522	95	May 31, 1980.
231: Mortgage insurance for housing for elderly	do	477	64,116	1,082,966,264	64,116	100	Cumulative through December 1979.
221(d)(3): Multifamily rental housing for low and moderate income families.	do	3,417	346,383	5,337,537,561	55,602	7	Do.
221(d)(4): Multifamily rental housing for low and moderate income families.	do	3,874	447,938	8,939,941,234			
235: Homeownership assistance for low and moderate income families.	Inactive [2]	[4] 472,059	473,032	8,456,560,790	(5)	(5)	Cumulative review program through May 1980.
	Active	40,862	40,893	1,352,920,895	(5)	(5)	
207: Multifamily rental housing	do	2,639	285,108	3,937,745,205	3,421	1.2	Cumulative through December 1979.
236: Rental and cooperative assistance for low income families	Inactive	4,052	434,645	7,479,970,182	53,799	12	Cumulative through December 1978.
202/236: 202/236 conversions	do	182	28,306	482,032,750	28,306	100	Do.
232: Nursing homes and intermediate care facilities	Active	1,271	[6] 145,262	1,581,565,981	145,262	100	Cumulative through December 1979.
Nonconstruction programs:							
8: Low-income rental assistance:							
Existing [7]	do	9,446	821,418	NA	240,742	29	Cumulative through May 31, 1980.
New construction [7] [8]	do	8,393	538,561	NA	290,447	54	Do.
Substantial rehabilitation [7] [8]	do	1,650	112,828	NA	40,107	35	Do.
312: Rehabilitation loans	do [9]	75,913	NA	780,225,000	NA	(10)	Cumulative through Sept. 30, 1979.
23: Low rent leased housing	Inactive [2]	NA	163,267	NA	54,000+	35±	Cumulative through December 1975.

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[1] Data does not indicate how many of these units are designed specifically for the elderly.

[2] Figures for original program reported through program revision.

[3] Figures for revised sec. 202/8 represent cumulative project reservations as of May 31, 1980.

[4] Figures represent number of mortgages.

[5] Figures not currently available.

[6] Beds.

[7] Figures represent cumulative fund reservations through reporting date.

[8] Figures do not include sec. 8 commitments attached to sec. 202/8 fund reservations.

[9] Figures represent loan commitments only.

[10] Approximately 25 percent of loans.

Source: This table was compiled by the Office of the Special Assistant for Elderly Housing and Special Programs, with the assistance of the Housing Budget Division, Management Information Systems Division, Multifamily and Single Family Insured Branches, and the Data Systems and Statistics Branch in the Office of Housing.

A. Section 202 Housing

Section 202 of the Housing Act provides for direct, low-interest construction and permanent financing loans for the development of housing projects especially designed for the elderly and handicapped. By law, sponsors are required to be nonprofit organizations and associations and have included religious institutions, union groups, community-based organizations, cooperatives, and fraternal organizations.

By the end of fiscal year 1980, HUD reported that 734 projects with approximately 69,000 units were approved under the 202 program, since the program's renewal in 1974. Of these projects, approximately 247 were completed with occupants in about 26,200 units.

A gross loan limitation level of $830 million was approved by the Congress for the 202 program in fiscal year 1980. HUD estimated that this amount would support approximately 18,000 units of housing. Earlier projections had shown $830 million to support approximately 20,000 units in 1980, but inflation and soaring costs decreased this estimate during the year.

During consideration of the budget and appropriations for fiscal year 1981, Senator Lawton Chiles offered motions to increase the gross loan limitation to $880 million which, according to Congressional Budget Office (CBO) projections, would be necessary to at least hold the number of units at the 1980 level. In a letter to the chairman of the Appropriations Committee's Subcommittee on Banking, Housing, and Urban Affairs, Senator Chiles described the section 202 program "as a tremendously successful program that is free of the high costs and management problems of other Federal housing programs."[2]

The Senate Appropriations Committee approved the $50-million increase in the Senate's fiscal year 1981 HUD appropriation bill (H.R. 7631). However, the House bill contained only $830 million and the Senate and House conferees agreed to split the difference leaving the total section 202 program with a loan limitation level of $855 million for fiscal year 1981 (Public Law 96–526). This increase was almost entirely negated by HUD when it carried out a congressionally mandated 2 percent cut in the overall HUD budget. The targets of the 2-percent cuts were left to the discretion of the Secretary who, along with OMB, decided upon a $24-million cut in the 202 program for fiscal year 1981.

The 202 program's loan limitation for fiscal year 1981 was thus left at approximately the 1980 level which could mean a substantial reduction in the number of units for the section 202 program.

B. Public Housing

The conventional public housing program under the Housing Act supports the greatest number of federally funded housing units. Elderly residents are eligible for units in most public housing units and some projects are especially designed for their occupancy.

According to HUD, there are approximately 1 million units of public housing in the United States of which 44 percent are occupied by an elderly person (age 62 and over). During 1980, 15,200 units of public housing were completed for occupancy and 5,200 were filled by elderly residents.

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[2] Letter to Senator William Proxmire, chairman of Subcommittee on Banking, Housing, and Urban Affairs, Senate Appropriations Committee, from Senator Lawton Chiles, chairman, Senate Committee on Aging, Aug. 18, 1980.

Public housing has experienced serious problems over the past few years. Reservations have decreased significantly due to problems with receiving sufficient operating subsidies to cover the program, a preference for section 8 subsidies, and difficulties in locating acceptable sites due to increasing land costs and rejection by communities.

One particular obstacle for low-income elderly in obtaining public housing units was removed by the 1980 amendments to the Housing and Community Development Act (Public Law 96-399). This obstacle previously had been a requirement that public housing have a mixture of incomes among the residents. As described in the following section of this chapter, this "tenant selection criteria" had resulted in low-income elderly being denied a unit in deference to a moderate-income person so that the project could meet its income mixture requirement. Under the new law, the Secretary of HUD can waive this criteria for public housing projects especially designed for the elderly.

C. SECTION 8 RENT SUBSIDIES

Since 1974, section 8 of the Housing Act has provided for rent subsidies on behalf of residents of public housing as well as private projects. Assistance can be provided for units in existing housing, new construction or for rehabilitated units. The resident pays 15 to 25 percent of his or her income for rent and HUD pays the owner the difference between the resident's payment and contract rent.

Those residents eligible for assistance under section 8 must have incomes below 80 percent of the median income in their area. In the Senate's version of the Housing and Community Developments Amendments of 1980 (S. 2719), the income eligibility level was decreased to 65 percent of median income. This change was deleted by the House and Senate conferees in the final bill (Public Law 96-399). It is expected that efforts to reduce the eligibility level to as low as 50 percent will be attempted in the 97th Congress.

According to HUD, 212,000 units of section 8 were reserved in 1980. Of these units, approximately 34 percent (or 73,000) were occupied by elderly persons.

D. SECTION 515

Section 515 of the Housing Act authorizes the Farmers Home Administration (FmHA) to provide low-interest loans to sponsors of rental projects in rural areas. FmHA has an agreement with HUD which assures that 10,000 units of 515 housing will receive section 8 assistance for each year. In addition, FmHA has a separate rental assistance program which provides rent subsidies to eligible tenants.

Since its beginning in 1970, section 515 has supported approximately 224,000 units of which 40,000 were initiated in 1980. Estimates of the National Rural Housing Coalition show that about 50 percent of the 224,000 units are occupied by elderly persons. Elderly and handicapped persons are required to receive priority under the 515 program.

E. CONGREGATE SERVICES

In 1978, the Congress created the congregate housing services program (CHSP) as a part of the Housing and Community Development Amendments of 1978 (Public Law 95–557). Under this program, HUD is authorized to make grants to public housing projects and section 202 projects to assist the projects in providing "supportive services" to the more frail elderly and handicapped residents. The law mandates that supportive services must include "full meal service" and may include "housekeeping aid, personal assistance, and other services essential for maintaining independent living."

Housing projects are required by law to coordinate services under CHSP with the local area agency on aging and guarantee that no services provided to eligible residents are duplicative of services already accessible to the participants. Former Secretary of HUD, Moon Landrieu, described the programs as a "cost effective means of enabling handicapped or temporarily disabled elderly individuals to remain in their own homes. It is an alternative to costly and unnecessary institutionalization that at the same time maintains the dignity of the individual."[3]

During 1980, HUD made the second round of awards under the congregate services program. However, only $6 million of the $10 million 1980 appropriation was obligated to existing projects. The remaining 1980 funds, which were intended for new construction, were still not obligated by the first of 1981. The holdup appeared to be tied to the administration's decision in the 1982 budget request to rescind the 1981 budget for congregate housing services.

The $6 million awards went to housing projects across the country to develop congregate services programs. Those projects included:

Project:	*Location*
Golden Age Village	Monterey Park, Calif.
Posada de Colores	Oakland, Calif.
Cathedral Plaza	Denver, Colo.
Oakville Home for the Independent Living	Hartford, Conn.
Federation Towers	Miami Beach, Fla.
Martin Fine Villas	Miami, Fla.
The Protectory	Lawrence, Mass.
Ravoux Plaza	St. Paul, Minn.
Kingsbury Terrace	St. Louis, Mo.
Bell House	Greensboro, N.C.
Aster Dowdy Towers	High Point, N.C.
New Horizon Manor	Fargo, N. Dak.
Elderly Care Center	Laguna, N. Mex.
Channelwood II	Akron, Ohio
Pioneer Plaza	Tulsa, Okla.
Opportunities Housing for the Elderly	Philadelphia, Pa.
Redbird-War Eagle Elderly	Wagner, S. Dak.
Small Group Home	Oshkosh, Wis.

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[3] News release, U.S. Department of Housing and Urban Affairs, Office of Public Affairs, Sept. 25, 1980.

II. HOUSING AND COMMUNITY DEVELOPMENT AMENDMENTS OF 1980

The Housing and Community Development Amendments of 1980 (Public Law 96–399) contributed little to the expansion or change of Federal housing programs. Major changes were proposed—such as the establishment of a new moderate-income program and the lowering of the income eligibility level for section 8 rent subsidies—but were eventually contested, defeated, and struck from the final bill approved by the Congress.

Several changes in the 1980 amendments do contain provisions which directly affect the elderly resident. These changes are described in the following pages.

A. CHANGE IN THE TENANT SECTION CRITERIA

Public Law 96–399 amends the Housing Act's tenant selection criteria which requires that public housing projects have an income mixture of residents. The new language gives the Secretary of HUD authority to waive this requirement for projects especially designed for the elderly in order to avoid rejection of low-income elderly as tenants. Senator David Durenberger, sponsor of the amendment, explained the rationale behind his amendment:

> There are long lists of low-income elderly waiting to get into the projects. But in order to qualify under the mix provisions of the law, these projects must provide housing to the elderly nonpoor in order to accommodate the low-income or elderly poor.[4]

B. PREPAYMENT OF SECTIONS 514 AND 515 LOANS

The new law contains a provision which repeals the Housing Act's restrictions on the prepayment of loans under the sections 514 and 515 rural housing programs. The result of allowing prepayments, prospectively as well as retroactively, permits owners of 514 and 515 projects to sell property whose units were intended as housing for low- and moderate-income persons.

During debate on this issue, concern was expressed that the displaced elderly tenants of such units could encounter severe hardships when faced with locating alternative housing. In a letter to the conferees for the Housing and Community Development Amendments of 1980, Senator Lawton Chiles and Representatives Claude Pepper and Edward Roybal expressed their concern:

> If this provision prevails in conference, we urge that reasonable provisions be contained in the law which assure that in those projects whose loans are prepaid, the elderly tenants are not deprived of their units or at least are assured of alternative housing in the area. In many rural communities across the country, reasonably priced rental units are scarce and

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[4] Durenberger, David. Amendment to the Housing Act of 1974. Remarks in the Senate. Congressional Record, vol. 123, June 21, 1980, p. 7720.

> the sections 514 and 515 programs have been a successful source for decent and affordable housing for many elderly. Recognizing that this was the precise intent of the law, we would hope that the capability of providing for low- and moderate-income elderly will not be thwarted.[5]

In response to such concern, the conferees agreed to allow prepayments but with the following qualifications:

> (1) If any loan which was made or insured under section 514 or 515 pursuant to a contract entered into before December 21, 1979, is prepaid or refinanced on or after the date of enactment of the Housing and Community Development Act of 1980, and tenants of such housing and related facilities financed with such loans are displaced due to a change in the use of the housing, or to an increase in rental or other charges, as a result of such prepayment or refinancing, the Secretary shall provide such tenants a priority for relocation in alternative housing assisted pursuant to this title.
>
> (2) The Secretary of Agriculture shall conduct a study of, and report to the Congress not later than 6 months after the date of enactment, any adverse effects the amendments made by subsection (a) may have on housing, particularly for the elderly and persons of low income.[6]

C. SECTION 312 REHABILITATION FOR CONGREGATE HOUSING AND SRO's

The 1980 amendments expand the section 312 rehabilitation program's maximum loan amounts for residential property to include congregate housing facilities in which all units do not contain kitchen facilities but have a central dining area and facilities in which all units do not contain bathrooms or kitchens, commonly referred to as "single-room-occupancies or SRO's." These facilities which often house elderly persons are therefore eligible for rehabilitation and improvement loans under the section 312 program at a rate of $25,000 per unit in congregate housing and $15,000 per unit in SRO's.

D. MINIMAL PROTECTION FOR CONDOMINIUM DWELLERS

What was originally intended to protect tenants whose dwellings were faced with conversion to condominiums and cooperatives and protect condominium and cooperative owners from unconscionable recreational leases was watered down to very minimum protection by the conferees on the Housing and Community Development Amendments of 1980 (Public Law 96–399).

The original legislation, introduced in the Senate by Senators Dick Stone and Lawton Chiles (S. 612), and later incorporated into Senator Williams' housing reauthorization bill (S. 2719), provided for a greater degree of protection, especially for tenants whose dwellings face conversion. The Senate bill had provided for specific time and condition responsibilities for developers about notifying tenants whereas the conference version of the legislation merely calls for "adequate notice."

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[5] Letter to conferees on the Housing and Community Development Amendments of 1980 (S. 2719) from Senator Lawton Chiles, chairman of the Senate Committee on Aging, Representative Claude Pepper, chairman of the House Committee on Aging, and Representative Edward Roybal, chairman of the Subcommittee on Housing and Consumer Interests, House Committee on Aging, Sept. 12, 1980.

[6] Section 314 of Public Law 96–399.

Other provisions contained in the new title VI (Condominium and Cooperative Conversion Protection and Abuse Relief) are described below:

—The new title requires that developers provide adequate notice to tenants and give them the first opportunity to buy the unit in the converted building. However, the conferees point out "that the Congress believes it is the responsibility of State and local governments to provide for such notice and opportunity to purchase in a prompt manner . . . the Congress has decided not to intervene, and therefore leaves this responsibility to the State and local governments to be carried out." [7]

—The conferees express the intent of Congress that lending by federally supported institutions for the purpose of converting rental dwellings into condominiums or cooperatives should be discouraged when "there are adverse impacts on the housing opportunities of the low- and moderate-income and the elderly and handicapped individuals involved." [8]

—The new law provides judicial remedy for owners of condominiums and cooperatives who are affected by long-term leasing arrangements for recreational facilities. However, such action can only be brought when there is a vote of agreement by two-thirds of the owners association. To seek alleviation, the owners must prove that leases are unconscionable. According to the law, an unconscionable lease is one with all of the following characteristics:

(1) It was made in connection with a cooperative or condominium project.

(2) It was entered into while the cooperative or condominium owners' association was controlled by the developer either through special developer control or because the developer held a majority of the votes in the owners' association.

(3) It is for a period of more than 21 years or is for a period of less than 21 years but contains automatic renewal provisions for a period of more than 21 years,

(4) It contains an automatic rent increase clause; and

(5) It was entered into prior to June 4, 1975.

—Title VI provides for termination of "self-dealing" contracts which have been entered into after the effective date of the title. A self-dealing contract is one which relates to operation, maintenance, or management of a conversion project or of any property serving the owners in such project. Termination of such contracts may occur at any time without penalty within a 2-year period beginning on the date on which special developer control is terminated or the developer owns 25 percent or less of the units in the converted project, whichever comes first.

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[7] U.S. Congress. Senate Committee on Banking, Housing, and Urban Affairs and House Committee on Banking, Finance and Urban Affairs. "Conference Report (to accompany H.R. 2719)" report No. 96–1420, Sept. 26, 1980, p. 167.

[8] Ibid., p. 163.

The full impact of "condominium conversion" on the elderly tenants is still cloudy. Some argue that conversion has contributed significantly to the decline in rental units for the elderly. The Department of Housing and Urban Development in a congressionally mandated report on conversion states:

> It has been reported that elderly persons are more likely than others to feel the pressure of conversion and to be anxious about the prospects of relocation or about having to make a substantial investment in purchasing their unit. Some have suggested that elderly tenants who ultimately purchase their units are "distressed purchasers," who buy because they have no other choice. There is some support for these contentions, but it appears as if not wanting to move is a more persuasive explanation than the unavailability of alternative housing or the pressures and anxieties associated with purchasing.[9]

Whatever the extent of the effects of conversion, it is expected that the 97th Congress will have to address the issue more extensively than did the 96th Congress.

III. INVESTIGATION OF FEDERALLY FUNDED HOME REHABILITATION PROGRAMS FOR THE ELDERLY IN NEW MEXICO

Continuing its efforts to monitor the effectiveness of federally funded projects which directly impact upon the health and welfare of senior citizens, the U.S. Senate Special Committee of Aging held hearings in Santa Fe, N. Mex., and Washington, D.C., to take testimony and examine charges of fundamental abuses in home rehabilitation programs for the elderly.

The investigation was requested by New Mexico Senator Pete V. Domenici, after complaints from elderly citizens first surfaced at an earlier hearing on April 11, 1980. At that time senior citizens from rural communities of San Miguel, Mora, and Rio Arriba Counties met with Senator Domenici to discuss the "Rural Elderly—the Isolated Population: A Look at Services in the 80's." Federal programs initially reviewed included weatherization, energy assistance, and housing rehabilitation. Because of the magnitude of dissatisfaction in the overall effectiveness and ultimate performance of these programs expressed by many rural elderly, Senator Domenici asked for and received permission to proceed with a preliminary investigation to determine the extent of these complaints.

The committee secured the services of an investigator, Dr. Martin La Vor, who submitted an initial investigative report on June 27, which documented the following abuses:

—Federal funds utilized to improve the home and lives of poor and elderly rural New Mexicans have been committed but have not in many cases reached the targeted population.

—Work which actually has been started is of poor quality and generally incomplete.

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[9] U.S. Department of Housing and Urban Development. Office of Policy Development and Research. "The Conversion of Rental Housing to Condominiums and Cooperatives: A Study of Scope, Causes, and Impacts." Washington, D.C., June 1980, p. IX-8.

- There is evidence of "nepotism" involved in the awarding of grants, distribution of funds, and selection of contractors.
- Farmers Home Administration (FmHA) and Community Services Administration (CSA) guidelines and procedures for awarding grants—are "so loose," they appear to be designed for misuse.
- Official records and reports were incomplete and many times unavailable.

Acting on the investigator's findings, the full committee voted 8–0, to authorize subpenas and pursue the investigation. The scope of the probe was expanded to include all federally funded programs in New Mexico actively involved in assisting the elderly to rehabilitate their homes.

Conducting the October 8 hearings in Santa Fe were Chairman Lawton Chiles, and Senators John Melcher and Pete Domenici. Witnesses included elderly recipients of housing rehabilitation grants, contractors, and State and local program administrators from the FmHA.

The second investigative report dated October 8, revealed the following inconsistencies in administering FmHA programs:

- FmHA officials continually referred to funding under section 504 as "so small—only $24 million—that it falls through the cracks."
- Department of Agriculture spokesmen acknowledged that the Inspector General, "rarely evaluates" section 504 programs separately; in point of fact—only three audits for all section 504 programs in the entire United States have been undertaken during the last 3 years.
- Onsite inspection of rehabilitated homes are rarely undertaken by FmHA personnel. Case files are merely "spot checked," to determine if Federal funds are spent properly.
- FmHA rules and guidelines were neither enforced nor followed in many cases, and in some, the actual guidelines were not known or understood by officials employed to enforce them.
- Federal funds were disbursed to contractors and their work certified as "complete, family happy," even though onsite inspections by Aging Committee investigators refuted these contentions.
- FmHA officials admitted to personal intervention on behalf of "friendly" contractors who were in actuality family members of FmHA employees.
- Shoddy workmanship, inferior materials, unqualified contractors were the rule not the exception.
- Programs funded by different agencies and authorized by different laws appear to be used for the same purposes.
- Funds provided by one program were used to "correct or redo" work already completed by another agency.

Commenting on information on abuses uncovered by the investigation and hearings, Senator Domenici offered this statement:

> These examples of abuse and improper administration of home rehabilitation programs are but a few of many exposed by our investigations. They vividly illustrate the frustrating barriers which have been erected between the elderly and

> agencies of the Federal Government mandated to assist the poor, the handicapped, and the aged.
>
> Money alone is not enough. We must have individuals administering these programs who care for human dignity. We must have programs which work.
>
> It is incumbent upon the Congress and the appropriate departments of the Federal Government to reevaluate procedures governing section 504 and take immediate corrective action.[10]

The second investigative report contained a series of proposed recommendations for the Special Committee on Aging and the various agencies involved to consider. These options included:

- *A complete review by the General Accounting Office (GAO) of all housing rehabilitation programs serving the elderly.* The GAO would explore the need to consolidate the maze of separate authorizations into a more coherent service delivery mechanism. The findings of the GAO study would be shared with appropriate authorizing committees of Congress.
- *Expedite investigative procedures.* Inspectors General for the Departments of Agriculture, Housing and Urban Development, Health and Human Services, Energy, and the Community Services Administration, should develop streamlined methods to insure that any evidence of criminal activity uncovered through audits are promptly investigated and referred to the U.S. attorney for prosecution.
- *Bridge gap between audit and investigation.* There is an obvious gap between an agency's audit division which corrects systematic deficiencies and its investigative division charged with prosecuting criminal conduct. Some problems go uncorrected because they fall into the middle ground between the two. Congress should enact legislation to eliminate this gap and strengthen project accountability.
- *Joint Inspector General audits on a statewide basis.* To detect duplication of projects and possible double payments for the same work, coordinated audits on a statewide basis by the various funding agencies is absolutely essential. Coordination with State auditors—where States have similar programs—should be mandatory.
- *Coordination of vulnerability assets.* If not already implemented, Inspectors General should coordinate the risk analysis for programs or vulnerability assessments. This will afford the opportunity of eliminating duplicate projects and duplicate payments for the same work under similar programs.
- *Increase audit team effectiveness.* It is imperative that elderly recipients of benefits trust officials with whom they lodge complaints. Without this trust, disclosure of program deficiencies and abuse is not possible. Many times the only person at home is an elderly woman. Audit teams should include women. Also, in some

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[10] Special Committee on Aging hearing, Santa Fe, N. Mex., Oct. 8, 1980.

areas of the country, minority representation on audit teams is necessary.

—*Mandatory onsite inspection.* Any program audit must include onsite inspections of actual work performed together with a review of documents and files.

—*Selective prosecution.* Prosecution of documented cases involving fraud is necessary to establish the integrity of federally funded projects within section 504. Individuals who attempt to receive Government moneys while continuing to do shoddy work must be put on notice that failure to meet specific contractural obligations will not be tolerated.

Senator Domenici concluded the October 8 hearings of the committee with this assessment of Government-funded home rehabilitation programs:

> After participating in these hearings and interviewing many officials in responsible Government positions as well as receiving reports from others not directly involved, one must conclude that our findings in New Mexico are not unique to this State. There is a very real and distinct possibility that similar problems can be found in home rehabilitation projects in other States.
>
> My conclusion finds support in the extensive reviews completed on a national basis with respect to the HUD rehabilitation programs which are quite similar in many respects to the 504 program.
>
> A summary of HUD survey entitled, "Special Operations Survey Community Development Block Grant Rehabilitation Activities," indicates many of the same problems identified in our New Mexico investigation exist nationwide in similar programs administered by HUD.

Following the October 8 hearings, Senator Domenici asked officials of the Farmers Home Administration office in Washington, D.C., to meet with Aging Committee staff members to discuss the ramifications of sworn testimony previously received and review the procedures FmHA intended to take to insure that:

(a) Problems focused on in New Mexico do not exist elsewhere in the program.

(b) These problems will not occur elsewhere.

(c) Corrective action by FmHA to properly repair those homes which received incomplete or shoddy work.

Several weeks later Gordon Cavanaugh, Administrator of FmHA responded by letter to Senator Domenici's requests.

Administrator Cavanaugh outlined immediate steps to prevent further abuses. These modifications in FmHA procedures included:

—Assignment of another county supervisor to the office where the problem situation existed.

—An administrative notice sent all offices alerting staffs to the types of problems discovered, together with guidelines on ways to prevent future problems.

—Thorough audits of all FmHA section 504 grants programs by the Inspector General's office.

—Scheduling of an early 1981 training session by the FmHA national office for personnel administering section 504 programs.

Commenting on the question of necessary corrective action by FmHA to properly repair homes which received initially incomplete or shoddy work, the Administrator concluded:

> The FmHA has no legal basis to provide assistance to persons whose homes were not properly repaired unless the amount of the 504 grant originally provided was less than the $5,000 legal maximum or the family could not qualify for a 504 loan at 1 percent interest. Total grant assistance cannot exceed $5,000 and total loan or combination loan and grant cannot be more than $7,500.

Senator Domenici characterized the FmHA response as "inadequate, a useless exercise." The Senator further stated:

> I have to tell you that even though this is not a big program . . . I am concerned because a number of my constituents have had their expectations dashed by what I consider to be poor management at the local level by those who administer your (FmHA) program.
>
> When a private citizen is clearly hurt by the actions or inactions of a Federal agency . . . then I think these people have a right to expect a redress of their grievances. To date, I regret to say, Farmers Home has seemed strangely impotent in its efforts to locate resource needed to repair these homes.[11]

Because of FmHA's inaction Senator Domenici requested a second hearing. Called to testify in Washington, D.C., December 19, were: Hon. Thomas F. McBride, Inspector General of the Department of Agriculture; Hon. Gordon Cavanaugh, Administrator, Farmers Home Administration; Hon. Alex Mecure, Assistant Secretary for Rural Development, Department of Agriculture.

Senator Domenici convened the hearing with these words:

> The purpose of this hearing is to attempt to get some real answers from you gentlemen at the highest level.
>
> I am still not sure that you all understand and feel what we, who have seen these houses and have viewed this episode, feel.
>
> I thought you should come here and answer some questions and maybe we can once and for all put this behind us.

Under questioning by Senator Domenici, Agriculture officials acknowledged:

—Corrective action should have been taken when information of 504 program abuses is received. In matter of fact some 8 months expired before any criminal investigation was instituted.

—When an investigation reveals a disciplinary problem, there is a "semiparalysis" in the decision process because the Department of Agriculture will not take any action while charges are "pending."

—FmHA management and support staff have a serious "competency problem."

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[11] Special Committee on Aging hearing, Washington, D.C., Dec. 19, 1980.

—Department of Agriculture regulations and procedures were not followed by their own employees.
—There is no consistent monitoring of 504 projects.
—The 20 or more families whose homes are still not livable are "out in the cold." Department of Agriculture has no authority to make reparations. Current legislation does not permit indemnification for faulty construction.
—Bonding and State licensing of 504 prime contractors has not been required.
—There has been a breakdown in procedures protecting elderly grant recipients against fraud and forgery.
—There are not enough qualified FmHA building inspectors or onsite progress inspections to meet minimum New Mexico State requirements.

After listening to and questioning Department of Agriculture officials, Senator Domenici offered these observations:

> I don't want to abuse the hearing process. There is no way I want to have hearings on hearings on hearings on this issue. I have gone as high as I intend to go in the Department of Agriculture. I can say that if we don't find a way to at least offer some help, I clearly intend to take it out of some other program of the Department of Agriculture. I am going to do it.
>
> I am going to get money appropriated to help these poor people get at least some of what we have already paid for. It just seems to me that we are dancing all around this issue. We have to find a way to solve their problems.
>
> We hope we have solved the FmHA management problem. I am not sure we have, but at least we have pointed it up for you.

Senator Domenici concluded the last phase of his investigation with several suggestions for immediate attention and implementation by the Department of Agriculture and FmHA officials:

(1) A national audit of all 504 programs to be completed by April 1981.

(2) An early warning monitoring system of 504 projects to detect deficiencies before they are incorrectable.

(3) Use of State building inspectors to supplement FmHA personnel.

(4) A study of bonding and licensing procedures for prime 504 contractors.

(5) Preparation of a legal brief by the Department of Agriculture General Counsel to determine if 504 grant recipients who were defrauded have any legal redress.

Chapter 8

CONSUMER ISSUES

CHAPTER HIGHLIGHTS

Legislation to set minimum standards for medi-gap insurance policies sold to the elderly was signed into law, and the Department of Health and Human Services issued proposed regulations for a program of voluntary certification of medi-gap insurance policies. Reauthorization of the Federal Trade Commission reflected the views of some in Congress that the Commission had become too activist in recent years. Legislation to phase out ceilings on interest rates was also passed. It is anticipated many elderly with small savings accounts will realize much higher interest rates as a result.

I. MEDI-GAP INSURANCE PROTECTIONS BECOME LAW

On June 9, 1980, the President signed into law the Social Security Disability Amendments of 1980 (Public Law 96-265), which include provisions to establish a program of voluntary Federal certification of medi-gap health insurance policies by July 1, 1982, in those States which have not implemented a regulatory program meeting the law's minimum standards by that date.

Versions of the medi-gap amendments were introduced in the Senate in 1979, by Senators Chiles, Dole, and Baucus, and cosponsored by Senators Glenn, Bradley, Pryor, Cohen, Heinz, and Melcher, members of the Special Committee on Aging. Bills were introduced in the House of Representatives by Congressmen Brodhead, Pepper, Scheuer, and others.[1] The Senate considered and passed the amendments on January 30, 1980, as part of H.R. 3236, the Social Security Disability Amendments of 1980. Final approval came when the legislation was accepted by House conferees.

A. Provisions of the New Law

The new law sets minimum standards for private health insurance policies sold to supplement medicare and requires all States to implement a medi-gap regulatory program to enforce standards equal to or stronger than Federal standards by July 1, 1982. The Secretary of the Department of Health and Human Services, working with a panel of four State insurance commissioners appointed by the President, will determine if each State meets this requirement. In any State where the requirement is not met by July 1, 1982, the Secretary is authorized to certify all medi-gap policies sold in that State which meet the minimum Federal standards.

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[1] See "Developments in Aging: 1979," part 1, pp. 155-165, for a discussion of these bills and other medi-gap actions during 1979.

The new law also sets Federal criminal penalties (a fine of up to $25,000 and imprisonment for up to 5 years) upon conviction of: (1) Furnishing false information to the Secretary to obtain policy certification; (2) posing as a Federal agent to sell medicare supplemental policies; and (3) knowingly selling duplicative policies to medicare-eligible individuals. The sale of any medicare supplemental policies by mail would also be subject to the Federal penalties unless the policy in question had: (1) Been approved by the State under its own standards program or certified by the Secretary of the Department of Health and Human Services under the voluntary certification program, and (2) the State had not specifically disapproved the policy for sale in that State.[8]

The Department of Health and Human Services is required to provide all medicare beneficiaries with information on the types of private health insurance available to supplement medicare benefits. The Department also must prepare, in coordination with the Federal Trade Commission, an analysis of the effectiveness of different State approaches to regulation of medicare supplemental health insurance sales, with a report to Congress by January 1, 1982.

B. THE STANDARDS FOR MEDI-GAP POLICIES

The minimum standards adopted by Congress are, in large part, those which were recommended by a special task force on medi-gap insurance formed by the National Association of Insurance Commissioners in 1978, after Senate Committee on Aging hearings had brought the issue to national attention. Minimum requirements for policy loss ratios (the ratio of premiums collected to benefits paid on a particular policy issue) were added by the legislation.

The law sets the following minimum standards for medi-gap health insurance policies sold to medicare-eligible persons:

—A policy must cover medicare part A (hospital insurance) coinsurance amounts for the 61st day of medicare coverage through the 90th day (currently $51 a day) and lifetime reserve period (currently $102 a day), and 90 percent of hospital charges beyond the lifetime reserve period up to 1 year.

—A policy must cover 20 percent of medicare part B (supplementary medical services) reasonable charges (the copayment amount set in the medicare program) up to a maximum amount of $5,000 per calendar year.

—A policy must have no more than a 6-month limitation on preexisting condition restrictions.

—A policy must have a minimum loss ratio experience of 75 percent for group policies and 60 percent for individual policies.

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[8] Public Law 96-265 provides for exemptions from the penalties for certain specific types of policies and circumstances, such as group health policies of employers or labor organizations. The intent of Congress in these areas is expressed in the conference report on the legislation. U.S. Congress. "Social Security Disability Amendments of 1980." Conference report on H.R. 3236. House of Representatives report No. 96-944, May 13, 1980, p. 75.

—The buyer must have a right to return a policy without loss of premiums within 10 days of sale for agent-sold policies, and 30 days for policies sold through the mail.

—Potential buyers must be provided with an information pamphlet describing the different types of medi-gap insurance available at the time of application for purchase.[3]

—The potential buyer must be provided with an "outline of benefits" form which clearly states policy benefits, costs, limitations, rights to cancel, and comparison with medicare benefits at the time of application for purchase.

C. IMPLEMENTATION OF THE NEW LAW

On October 30, 1980, the President appointed the commissioners of insurance from the States of Connecticut, Wisconsin, Arkansas, and Utah to serve with the Secretary of Health and Human Services on the panel to evaluate State medi-gap regulatory programs. Guidelines are expected to be provided to all States early in 1981 on information the panel will need to determine compliance with the law. The panel is required to report to Congress, on or before January 1, 1982, those States which are not expected to have an operational medi-gap regulatory program in place by the deadline of July 1, 1982.

Proposed regulations for implementation of the voluntary certification program were published in the Federal Register on January 21, 1981,[4] with a 60-day comment period. The proposal sets guidelines for use of a Secretarial "seal of approval" for insurance policies meeting approved State guidelines as well as those meeting minimum Federal standards.

Illinois, Florida, Maryland, Nebraska, and Tennessee are among the States which passed new medi-gap laws during 1980. Additional regulatory authority is being considered in Arizona, Virginia, New Jersey, and New York. Under the terms of the legislation, a majority of States may have met the minimum standards for regulation of medi-gap sales by the deadline date of July 1982. Federal voluntary certification programs would only be operational in States which do not meet the requirements.

Some States already have established a regulatory program which utilizes higher standards for policy content and sale than the minimums developed by the National Association of Insurance Commissioners or required by Federal law. This was, in fact, the intent of the law.[5] Information on the effect of these standards, and different approaches taken by States, should be useful to all States as they develop new regulatory programs.

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[3] The Department of Health and Human Services has published and made widely available a pamphlet entitled "Guide to Health Insurance for People with Medicare," including a revised 1980 version. The pamphlet was jointly developed by the Department and the National Association of Insurance Commissioners, and is available in all Social Security district offices and from the Health Care Financing Administration, Department of Health and Human Services, pub. No. HCFA–02110. A number of States have also developed their own versions of this pamphlet for agent use within that State.

[4] Proposed rule. "Medi-gap—Certification of Medicare Supplemental Health Insurance Policies," Federal Register, vol. 46, No. 13, Jan. 21, 1981, p. 6296.

[5] See conference report on legislation. "Social Security Disability Amendments of 1980," House report No. 96–944, and remarks in the Senate of Senators Chiles, Baucus, Domenici, Bradley, Metzenbaum, Congressional Record, Jan. 30, 1980, pp. 633–642.

II. FTC POWERS LIMITED BY CONGRESS

Legislation to reauthorize the operations of the Federal Trade Commission (FTC) proved to be controversial, as Congress moved to restrict the agency's rulemaking powers. Objections were registered against a number of rulemaking proceedings which have been of particular interest to elderly consumers—including insurance sales practices and longstanding efforts to define unfair selling practices in the funeral industry.

Public Law 96–252, effective May 28, 1980, contained the following amendments of significance to the elderly:

Changes to funeral industry rule: The FTC may now issue final rules governing sales practices within the funeral industry, but the final rule must be limited to mandating price disclosures, banning deceptive or coercive practices, and prohibiting unlawful practices such as boycotts or threats.

The earlier version of the reauthorization bill approved by the House of Representatives (H.R. 2313, passed by the House on November 27, 1979) would have restricted the FTC from issuing any rules governing the funeral industry. The FTC had documented a wide range of abuses within the funeral industry during a period of 4 years, and a staff report issued in 1978 with proposals for prohibiting questionable sales practices and requiring item by item price disclosures met with strong industry opposition.[6]

The compromise reached by House and Senate conferees will allow the FTC to proceed with some aspects of the rule as originally proposed. A revised proposed rule was issued by the FTC on January 22, 1981.[7]

Prohibitions against insurance investigations: The FTC reauthorization bill also prohibits the FTC from conducting investigations into the "business of insurance" unless a specific study is requested and approved by a majority vote of either the Senate or House Commerce Committees. If the FTC is authorized to conduct any insurance study through such a request, the study activity would cease with the election of a new Congress as committee members change, unless specifically renewed by a new committee.

The House and Senate conferees made it clear, through report language, that authority to conduct studies be limited to general review and analysis of insurance policy issues, not "investigations" of the industry or segments of the industry. Report language also made clear the House and Senate conferees' intent that insurance is to be regulated by the States only.[8]

Challenges to insurance industry investigations and studies originated in the Senate version of the bill (S. 1991, passed by the Senate on February 7, 1980). During debate in the Senate, however, Senator Lawton Chiles, then-chairman of the Committee on Aging, successfully offered an amendment to exempt the FTC's ongoing study of medigap insurance sales to the elderly from the blanket prohibition against insurance studies. The amendment was contained in the final version of the bill signed into law (Public Law 96–252).

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[6] "Funeral Industry Practices." Final staff report to the Federal Trade Commission and proposed trade regulation rule, Bureau of Consumer Protection, Federal Trade Commission, 1978.

[7] "Funeral Industry Practices." Revised proposed rule. Federal Register, vol. 46, No. 14, Thursday, Jan. 22, 1981, p. 6976.

[8] U.S. Congress. House of Representatives. "Conference Report on Federal Trade Commission Amendments; Report To Accompany H.R. 2313." Washington, Rept. No. 96–917.

Therefore, with the exception of the FTC's continued work with the Health Care Financing Administration on the medi-gap insurance study required by the new medi-gap law,[9] all activities of the FTC staff in any way related to the "business of insurance" ceased when the authorization bill was signed. The FTC had completed a study of the value of cancer insurance policies, frequently sold to the elderly and the subject of earlier critical congressional hearings,[10] but the report was never released by the Commission.

Consumer participation cutbacks: The final bill also provides that no person (or group) may receive more than $75,000 in public participation funds for any single rulemaking proceeding, or more than $50,000 in any 1 year. The total authorization for the FTC's public participation program was reduced from $1 million to $750,000 per year.

The FTC's public participation program frequently allowed elderly consumers and other advocates to participate in the development of rules of interest to them (such as the funeral industry proposed rules). The program supports transportation and lodging, for example, of low-income individuals to testify at public hearings.

Congressional oversight of proposed FTC rules: The FTC is required to provide both the House and Senate Commerce Committees with advance notice of any proposed rulemaking 30 days before publication in the Federal Register. All final rules must be submitted to both the House and the Senate, and cannot become effective until after a 90-day period of congressional review. If, within this 90-day period, both the House and Senate adopt a resolution expressing disapproval, the rule is effectively vetoed.

III. INTEREST RATE CEILINGS PHASED OUT

Ceilings on the rate of interest paid on savings deposits will be phased out as a result of legislation passed by Congress and signed into law on March 31, 1980 (Public Law 96–221).

The legislation creates a six-member Depository Institution Deregulation Committee, which has a 6-year authority to control rates paid on deposits. At the end of the 6-year phaseout period, Government financial regulations on interest rates—collectively known as "regulation Q"—will expire.

The effort to phase out interest rate ceilings was initiated by a number of consumer organizations representing the elderly—particularly the Gray Panthers—because of their effect on keeping interest ceilings for small savers very low (5.5 percent), while allowing more affluent savers higher market rates of interest.[11]

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[9] See discussion of medi-gap law above.

[10] U.S. Congress. U.S. Senate and U.S. House of Representatives. "Cancer Insurance and the Elderly." Joint hearing of Subcommittee on Antitrust, Monopoly, and Business Rights of the Senate Committee on the Judiciary and Select Committee on Aging, House of Representatives. Mar. 20, 1980. Washington, Ser. No. 96–61.

[11] See "Developments in Aging: 1979," part 1, pp. 167–169, for a full discussion of these efforts.

Chapter 9

THE WHITE HOUSE CONFERENCE ON AGING

A LOOK AT THE CONFERENCE AND BEYOND

The 1981 White House Conference on Aging is more than a continuation of conference tradition—more than a "one-time" event. The Conference will reaffirm the Nation's commitment to the elderly through a mechanism which permits both the President and the Congress to draw national attention to the quality-of-life issues confronting older Americans.

The White House Conference on Aging, however, is a one-in-a-decade social policy phenomenon which both respects and upholds the belief of citizen participation in Government and in the decisions which affect their lives. It is both a series of events and a process whereby people from across the Nation can participate in the shaping of future policy.

The impact of the Conference will be measured over time in terms of commitments made by the Nation's leaders to implement a national policy on aging and to translate the post-Conference recommendations into legislative and administrative action. Final success lies in the extent to which the spirit of citizen participation generated in thousands of local communities and in all States continues to promote discussions and resolutions of the problems and opportunities for a longer life.

On October 18, 1978, President Carter signed legislation (Public Law 95–478) authorizing the third White House Conference on Aging to be convened in 1981. Authority to plan and conduct the Conference was delegated to the Secretary of the Department of Health and Human Services (HHS) and the Executive Director of the Conference. The White House Conference on Aging is scheduled to take place in Washington, D.C., from November 29 to December 3, 1981.

President Carter, explaining the need for the 1981 White House Conference on Aging at a reception held for the Advisory Committee at the White House on March 26, 1980, stated:

> Every day in our great country about 5,000 Americans reach the age of 65. And this is a very important time in their lives. It's a time either of increased choices in their life or a narrow restraint on their life. It's a time for the prospect of warm relationships with their families or their friends; it's a time of security and anticipation of a future that's stable, that will meet their needs, or it's a time of uncertainty and insecurity, and perhaps fear. It's a time of confidence about the coming days or it's a time of pessimism about their future life. This question, how Americans approach their 65th year and how they live their lives after the age of 65, will be the subject of the White House Conference on Aging.

I. HISTORICAL BACKGROUND

A. Legislative Mandate

The authorizing legislation for the 1981 White House Conference on Aging (Public Law 95–478) sets forth several pre- and post-planning requirements including:

—Providing Federal financial assistance to State and area agencies to help them hold local and State conferences prior to the White House Conference.

—Appointing and supporting an advisory committee for the Conference and such technical committees as may be needed to insure the success of the Conference.

—Conducting the Conference in such a way that the broad participation of older persons, including low-income and minority older persons, is assured; and

—Issuing a final report to the President and Congress, within 6 months of the conclusion of the Conference, which shall include a statement of, and recommendations for, implementation of a comprehensive, coherent national policy on aging, (HHS Secretary will submit recommendations for legislative and administrative action within 90 days after submission of the final Conference report).

The Secretary of HHS is mandated under the authorizing legislation to insure that current and adequate statistical data and other information on the well-being of older individuals in the United States is readily available to Conference participants in advance. In fulfillment of this Conference requirement, the Secretary may award grants to, or enter into contracts with, public agencies and/or nonprofit private organizations

B. Past White House Conferences on Aging

The White House Conference on Aging has a significant history evolving from an Executive order issued by President Truman in August 1950. Under the vested authority of the President, the Federal Security Agency (predecessor to the Department of Health and Human Services) invited 816 Americans to collectively discuss the issues of concern to its older population. This national meeting established a precedent for convening White House Conferences on Aging in the decades to follow.

Prompted by greater awareness and heightened social concern regarding an expanding older population, President Dwight Eisenhower signed legislation authorizing the first White House Conference on Aging to be convened in 1961. Foremost, the 1961 White House Conference on Aging included the participation of 2,500 delegates from across the country and served as the precursor to a number of significant legislative developments including the Older Americans Act of 1965; medicare; the National Housing Act Amendments; and the creation of a Subcommittee on Aging in the Senate, followed by the establishment of the Senate Special Committee on Aging.

Ten years later, the 1971 White House Conference on Aging charted an expanded administration and legislative course which resulted in the enactment of 77 percent of the Conference's most significant recommendations. Appearing before the final session of the 1971 Conference, President Richard Nixon pledged to support a fivefold increase in the AoA budget over his original budget request; a $100-million nutrition bill for the aging, the upgrading of nursing homes, and private pension reforms. Within 2 years, all of these commitments were translated into Federal legislation.

C. CONFERENCE LEADERSHIP

The initial planning of the 1981 Conference, begun in June 1979, was conducted under the direction of the Secretary of HHS and in conjunction with the Commissioner on Aging and the Director of the National Institute on Aging. In December 1979, former Congressman Jerome Waldie of California was appointed by HHS Secretary Harris to begin Conference planning activities and serve as its Executive Director. Shortly thereafter, Leon Harper of California was named to the position of Associate Executive Director.

The first major preconference activity was President Carter's December 1979, announcement naming the six key individuals who will spearhead the 1981 National Conference. Sadie T. M. Alexander, an 82-year-old attorney from Philadelphia (the first black woman in the United States to receive a Ph. D.), was named chairperson of the 1981 White House Conference on Aging. At the swearing-in ceremony convened at the White House, President Carter also appointed four deputy chairpersons: Dr. Arthur S. Flemming, former U.S. Commissioner on Aging and chairman of the 1971 Conference; Dr. Bernice Neugarten, psychology professor and gerontologist, Chicago, Ill.; Mrs. Lupe Morales, a community activist for Hispanics, Los Angeles, Calif.; and Dr. Ellen Winston, home health services advocate and former U.S. Commissioner on Welfare, Raleigh, N.C.

On March 21, 1980, HHS Secretary Harris released the names of a 55-member Advisory Committee for the 1981 White House Conference on Aging. Pursuant to the mandates of the authorizing legislation, the committee includes representation from the Federal Council on Aging, public and private nonprofit organizations, and individuals who work on behalf of the aged. The Advisory Committee's task is to assist and participate in the planning, convening, and reviewing of the Conference activities as directed by the White House Conference chairpersons.

II. 1980—A YEAR OF PREPARATION

The convening of the 1981 White House Conference on Aging will have been preceded by 19 months of preconference planning activities and events. These activities have been designed to insure a broad cross-section of citizen participation and to facilitate a thorough examination and development of issues for consideration at the national meeting.

Conference officials established two principal sources of issue development analysis and evaluation intended to insure that national attention to special aging issues is guaranteed—issues affecting particular populations or Federal policies and programs which would not be treated in depth through the local community or statewide citizen forum process. They are:

- —40 special concerns and problem-oriented miniconferences (reports due to the Conference office by February 15, 1981.
- —16 technical committees, each focusing on an issue area (reports due February 1, 1981.

A. MINICONFERENCES

The White House miniconferences, conducted between September 1980 and January 1981, provided a structure for the development of special issue areas, such as housing, vision, long-term care, and minority elderly, for consideration by Conference delegates in advance of the national meeting.

The miniconferences were organized and sponsored by a host of convenor organizations interested in exploring selected aging issues. Nearly 40 such miniconferences have been officially recognized and approved by the 1981 White House Conference on Aging and include the following subject areas:

- —Black elderly.
- —Hispanic elderly.
- —American Indian elderly.
- —Urban elderly.
- —Rural elderly.
- —Women.
- —Spiritual well-being.
- —Corporate sector.
- —Transportation.
- —Mental health.
- —Lifelong learning.
- —Energy.
- —Art and humanities.
- —Low vision.
- —Foot care.
- —Intergenerational.
- —Voluntary sector.
- —Euro-American elderly.
- —Recreation and leisure.
- —Pacific/Asian elderly.
- —Media.
- —Foundations.
- —Dental health.
- —Elderly poor.
- —Hearing impaired elderly.
- —Legal barriers.
- —Long-term care.
- —Savings.
- —Alcoholism.
- —Nonservices.
- —Senior centers.
- —Self-help and senior advocacy.
- —Consumer problems.
- —Legal services.
- —Patients rights.
- —National health insurance.
- —Older veterans.
- —Alzheimer's disease.
- —Environmental issues.
- —Housing.

An estimated $1.1 million has been provided by various Federal agencies, such as the Administration on Aging, the Social Security Administration, and the Community Services Administration, to support miniconference activities. Financial contributions from private funding sources have also been utilized in support of this issue development process.

The summarized reports and recommendations emanating from the miniconferences were to be submitted to the Conference office by February 15, 1981, for distribution to State conference delegates for their review and consideration.

B. TECHNICAL COMMITTEES

On August 5, 1980, Executive Director Waldie announced that Secretary Harris had appointed 135 individuals to serve on 16 issue-oriented White House Conference Technical Committees and stated:

> Through the assistance of the technical committees, delegates to the 1981 meeting will be well-prepared for educated decisionmaking, leading to a comprehensive and coherent national aging policy.

Total membership on the technical committees is composed of 50 advisory committee members in addition to the recent appointments of 85 citizens from throughout the country. Together, this group brings both professional and lay expertise to the committees in such fields as gerontology, economics, law, medicine, long-term care, minority affairs, private industry, labor, education, and religion.

The technical committees are charged with the responsibility of preparing background materials for delegates to the 1981 Conference. Foremost, the technical committees are expected to reach consensus in defining major issues for consideration at the national meeting. The 16 technical committees include:

—Retirement Income.
—Health Services.
—Health Maintenance.
—Long-Term Care.
—Family, Social Services, and Other Support Systems.
—Physical and Social Environment and the Quality of Life.
—Older Americans as a Growing Resource.
—Employment.
—Creating an Age-Integrated Society Within:
    Societal Institutions.
    The Economy.
    The Educational System.
    Religious Institutions.
    The Family.
    The Media.
    The Governmental Structure.
—Research.

C. NATIONWIDE CITIZEN FORUMS: SETTING THE STAGE

Consistent with the preconference planning activities occurring at the national level, a comparable number of events are scheduled in thousands of communities throughout the country in preparation for the national Conference. The Conference structure provides for organized events, such as local forums, State conferences, and regional hearings, to serve as vehicles for insuring the broadest citizen participation in the discussion of aging issues and in the formulation of recommendations for the 1981 White House Conference on Aging.

1. COMMUNITY FORUMS

Thousands of community forums were conducted nationwide during May and June 1980, sponsored by area agencies on aging and other interested organizations, to begin preparation for the national Conference. Information emanating from these local community forums articulated issues of dominant concern to citizens and was elevated to the State level for further discussion.

2. STATE CONFERENCES

Organized by State coordinators appointed by each Governor, State conferences on aging have been held or will be held in each of the States and U.S. Territories prior to June 1981. The State conferences are intended to permit public debate of quality-of-life issues concerning the elderly, to assimilate the views of citizens, and to translate these concerns into formal recommendations, based on consensus, which will be forwarded to the conference's leadership officials prior to the national meeting.

State conferences on aging are intended to serve as the forum for the selection of delegates to the national Conference. These conferences are financially supported by the Administration on Aging in the form of special grants to the States.

3. DELEGATION SELECTION

The White House Conference on Aging will convene on November 30, 1981, with 2,000 voting delegates. Travel and daily expenses will be provided for these voting delegates. An additional 2,000 Conference observers will be granted the opportunity of Conference participation which does not include voting privileges or travel cost reimbursements.

As a result of budget constraints, the 1981 Conference determined that the total number of voting delegates would not exceed 2,000, in striking comparison to the 3,500 delegates who attended the 1971 White House Conference on Aging or the 2,500 delegates participating in the first national Conference in 1961.

The selection of delegates adhered to the Conference's enabling legislation, and has been administered according to the following guidelines:

—1,000 delegates, divided among the 57 States and territories according to the proportion of the age 55 and older population of each of these jurisdictions. No State shall have less than six delegates. At least half of each State's delegation shall be female, and minority groups shall be represented in each delegation in the approximate proportion that such groups are found in the population of their respective States.

—539 delegates, one each to be chosen by the Members of Congress who were in office on February 1, 1981.

—Approximately 150 delegates granted such status because they are currently members of the 16 Conference technical committees, or are official coordinators appointed by the Governors in connection with preparations for their State conferences and the national Conference.

—The balance of delegates are to be named by the Executive Director of the Conference in the early summer of 1981, to assure that the racial, sex, age, and rural/urban profile of the overall delegate body closely parallels that of the Nation. Also, national organizations concerned with the aged and other groups will be asked to nominate some members of this last group.

Governors and Members of Congress were asked to initiate their respective delegate selection process by February 1, 1981. Numerous legislative officials have responded and the process of documenting delegates is well underway.

D. CONFERENCE BUDGET

Activities generated on behalf of the 1981 White House Conference were initially funded by a $3-million appropriation under the 1979 Supplemental Appropriation Act (Public Law 96–38). Although the Conference will not be conducted until late 1981, HHS estimated that at least 2½ years were needed for planning and preconference activities. As a result, funds from the initial appropriation were to remain available until expended.

The administration's fiscal year 1981 budget requested an additional $3 million for the WHCOA, which would bring the Conference appropriations to a total of $6 million. Since the fiscal year 1981 appropriation bills for most Federal agencies and programs were pending in mid-October, a continuing resolution to guarantee Federal funding was necessary. The second or further continuing resolution (Public Law 96–536) signed by President Carter on December 16, 1980, provided funding authority for the additional $3 million for 1981. This provision of the further continuing resolution was the result of action by Senator Chiles during Senate Appropriations Committee deliberations on the Labor and HHS appropriations.

Additional funding sources for the Conference include the Administration on Aging and the National Institute on Aging which made substantial financial contributions to the Conference. Other Federal agencies and national public and private organizations have assisted the 1981 Conference by way of partial funding of the miniconferences.

Chapter 10

ISSUES OF EMERGING AND CONTINUING CONCERN

I. LIFELONG LEARNING: EDUCATION FOR OLDER AMERICANS

The 1980 session of the 96th Congress enacted legislation to increase educational opportunities for those adults who have not been able fully to benefit from existing programs. Education outreach programs, in title I of the Higher Education Act, represent a stronger initiative for continuing education programs which address the needs of underserved adults, including the elderly, women entering or reentering the work force, the handicapped, the economically disadvantaged, and individuals whose previous educational experience has acted as a barrier to lifelong learning.

Other amendments to the Higher Education Act adopted by Congress addressed the need for research on the educational interests and requirements of older adults, as well as the need for more reliable data on older Americans' participation in federally supported education programs. Changes in student financial aid programs, such as allowing less than halftime students to qualify, alleviate some of the barriers adults face in obtaining grant and loan assistance.

In preparation for the 1981 White House Conference on Aging, a miniconference entitled "Lifelong Learning for Self-Sufficiency" was sponsored by the Institute of Lifetime Learning of the NRTA–AARP, the Adult Education Association's Commission on Education for Aging, the Association for Gerontology in Higher Education, and the Population Resource Center.

The U.S. Department of Education was established. The agency's motto, "Learning Never Ends," symbolizes efforts by organizations representing the elderly to insure that older Americans derive maximum benefits from Federal education programs. One focus of these efforts was to have a policy-level individual in the Department be responsible for coordinating programs in which the elderly can participate.

A. THE HIGHER EDUCATION ACT REAUTHORIZATION

1. REVITALIZING TITLE I, CONTINUING EDUCATION

Making federally supported postsecondary programs more responsive to the increasing numbers of nontraditional students seeking educational opportunities was one of the key issues facing the 96th Congress in the reauthorization of the Higher Education Act.

> The typical student is no longer young, no longer full time, no longer just out of high school, no longer a stranger to the world of work, no longer necessarily seeking either a set of skills, or an educational credential. And to be certain, he is no longer overwhelmingly "he." [1]

A number of factors have interacted to make the elderly an important force in the population of nontraditional students. Americans are living longer and enjoying better health in old age. Our society is "graying." As the baby boom matures, the demography is shifting from one dominated by the young to one in which adults and older persons represent a growing percentage. There is a trend toward early retirement, giving millions of Americans more years of creative "leisure." At the same time, increasing numbers of older persons are facing economic and psychological pressures either to postpone retirement or reenter the work force. Finally, the demands and complexities of our highly technological society and rapidly changing social structure are replacing the concept that one gains a set of skills in youth to last a lifetime with the idea that learning is a lifelong occupation.[2]

The House of Representatives passed legislation to authorize the Higher Education Act in 1979. The bill (H.R. 5192) contained provisions for focusing and revitalizing title I. Renamed education outreach, the House-passed version of title I targeted the program on the most severely underserved adults—those whose age, race, sex, handicap, national origin, rural isolation, poverty, or previous educational experience has acted as a barrier to their participating in education programs. Rather than relying solely on the Federal Government, the House sought to attract a wide range of resources—from business and industry, labor, public and private organizations serving adults and the elderly, State and local governments—to build a well-planned system of continuing education programs.[3]

The Senate retained the goals and purposes the House had envisioned for education outreach programs in title I, part B, State Planning and Continuing Education, in its reauthorization of the Higher Education Act, S. 1839 (S. Rept. 96–733). However, the Senate Labor and Human Resources Committee added two new sections to the title. A Commission on National Development in Postsecondary Education (part A) was authorized to study institutional changes necessary to respond to new economic and demographic trends. A three-part program of institutional adaptation and innovation (part C) was established to encourage institutions to update curriculae, serve women reentering the work force, and help disadvantaged youth make the transition to postsecondary education. The Senate passed S. 1839 on June 23, 1980.

Senate and House conferees, assigned to work out the differences between the House and Senate versions of the Higher Education Act reauthorization, refocused title I on lifelong learning and continuing education for underserved adults (Conf. Rept. 96–1337). As signed by the President on October 3, 1980, Public Law 96–374 retained parts A and B of title I, providing for a Commission on National Development in Postsecondary Education, and education outreach programs.

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[1] U.S. Congress. House of Representatives. Subcommittee on Postsecondary Education of the Committee on Education and Labor. "Reauthorization of the Higher Education Act and Related Measures." Hearings, 96th Congress, 1st session, part 2—Lifelong Learning, June 21, 1979, Washington, U.S. Government Printing Office, 1979, p. 120. (Opening statement of Representative William D. Ford, chairman.)

[2] For a detailed discussion of the educational needs and participation patterns of older Americans, see "Developments in Aging: 1979," part 1, pp. 215–218.

[3] Additional information on the purposes and provisions of the House version of title I may be found in "Developments in Aging: 1979," part 1, pp. 218–220.

The provisions for education outreach programs in title I–B center on State planning and programs to promote coordinated delivery systems of adult education opportunities. Ninety percent of the funds authorized for part B of title I are allocated to the States—60 percent of the allocation on the basis of relative adult population and 40 percent divided equally among the States (section 112). States must use between 15 and 20 percent of their allocation for comprehensive statewide planning (section 113). These planning provisions supplant and incorporate the State Postsecondary Education Commissions and planning activities which were authorized previously by title XII of the Higher Education Act (sections 1202 and 1203). Educational information centers, formerly authorized by title IV–A, subpart 5 (sections 418 A and B) of the Higher Education Act, are also transferred to the education outreach programs (section 114). Thus, the new title I–B brings under one program, State planning, information, and grant activities for continuing education, and eliminates duplicate reporting and submission of State plans.

The remainder of funds allocated to the States may be used to make grants and enter contracts with public and private organizations, higher education institutions, business, industry, and labor for programs to promote access to postsecondary education for adults who have been inadequately served (section 115). Such programs include a number of initiatives beneficial to older Americans, including:

—Legal, vocational, and health educational services and information for older individuals who use preretirement education as a means to adjust to retirement.

—Educational and occupational information and counseling services to aid adult women in entering or reentering the work force.

—Community education services for adults in rural areas.

—Postsecondary education programs for individuals who have been inadequately served, especially the handicapped, older persons, part-time students, migrants, and others who would be unlikely to continue their education beyond high school.

—The removal of barriers to continuing education caused by rural isolation and other rural-related factors.

Ten percent of the funds appropriated for title I–B are reserved for Federal discretionary grants (section 116). These grants may be used to develop innovative delivery systems to improve adults access to postsecondary education, expand the range of educational and community resources to meet the needs of underserved adults, promote telecommunications and other types of interstate delivery systems, develop statewide, regional, and national programs to coordinate educational and occupational information, and provide technical assistance to the States for their planning and program activities.

Title I–B also continues the authorization for the National Advisory Council on Continuing Education (section 117).

Congress is authorized to appropriate up to $20 million for education outreach programs for fiscal year 1981. The authorization level increases by $10 million per year, to $60 million for fiscal year 1985.

2. EDUCATIONAL DATA AND RESEARCH

When the Higher Education Act came before the Senate on June 23, 1980, Senator Lawton Chiles offered a series of amendments to promote research by the National Institute of Education (NIE) on the needs of nontraditional students, to make data on participation by older adults more readily available, and to authorize the Secretary of Education to study the remaining barriers faced by nontraditional students in pursuing educational opportunities. The amendments were adopted unanimously by the Senate and resulted in the following changes in the general education provisions:

—Included age, in the statement of purpose of the NIE as one of the criteria for insuring equal educational opportunity.

—Established, as one of the research and demonstration efforts of the NIE, the study of the special problems facing nontraditional students, including older and part-time students.

—Required annual evaluation reports of the Department of Education to tabulate data on the effectiveness of educational programs by age, when such data is available.

—Authorized the Secretary of Education to study any additional barriers to adult postsecondary education faced by nontraditional students.

The amendments were retained in the House/Senate Conference on the Higher Education Act Reauthorization. Since both House and Senate bills provided for a number of studies of postsecondary education and student financial aid, the conferees assigned the authority to study the barriers to postsecondary education faced by nontraditional students to the Commission on National Development in Postsecondary Education, title I–A.

3. INCREASING ACCESS THROUGH STUDENT FINANCIAL AID

Changes in the student financial aid provisions of the Higher Education Act, title IV, are designed to increase access to postsecondary education for adults and may prove beneficial to older Americans. Title IV–A authorizes higher education institutions to award up to 10 percent of their supplemental educational opportunity grants (SEOG's) to less-than-half-time undergraduate students (section 413C(c)). The previous requirement that students be enrolled on at least a half-time basis to qualify for SEOG's was regarded as a barrier to working adults, homemakers, and older persons who wish to continue their education.

Title IV–F, the general provisions relating to student assistance, was also amended by the Higher Education Act reauthorization to exclude home equity and an asset reserve of $10,000 (or $50,000 if net assets include a farm or business) from consideration of need for Federal student financial aid (section 482(b)(5)). Many working and retired adults have equity in their homes and an asset reserve which has precluded them from obtaining educational grants and loans, although their effective income is too small to cover continuing education expenses.

B. ESTABLISHMENT OF THE DEPARTMENT OF EDUCATION

May 4–9, 1980, marked the official opening of the U.S. Department of Education. Authorized by Public Law 96–88, the new Department chose as its motto, "Learning Never Ends," which underscores the importance of education as a lifetime pursuit. The opportunity for greater attention to the needs of nontraditional students provided by the creation of a separate Cabinet-level agency to administer the bulk of Federal education programs was viewed with optimism by organizations representing older Americans and adult learners.

While there are virtually no education programs authorized solely to benefit individuals aged 60 and over, almost every office of the new Department administers programs in which the elderly can participate and from which they can benefit. For example, the Office of Vocational and Adult Education directs the adult education program, which is designed to help educationally disadvantaged adults of all ages gain the basic knowledge and skills they need in an increasingly complex society. The Office of Postsecondary Education oversees programs authorized by the Higher Education Act, including title I continuing education programs and the fund for improvement of postsecondary education, which supports such activities as Elderhostel. In addition, the National Institute of Education and other parts of the Department administer a wide range of programs and support research and demonstrations which affect older Americans, including library services, career education, the community schools program, and bilingual education.

On December 13, 1979, Senator Chiles wrote the first Secretary of Education, Shirley M. Hufstedler, to request that an individual at the policy level be appointed to be responsible for and coordinate education programs benefiting older persons. In her formal response and at subsequent hearings of the Senate Subcommittee on Labor-HHS, Education Appropriations, the Secretary indicated her personal interest in seeing that the many programs of the Department meet the educational needs of the elderly, as well as enumerating the research and demonstration efforts the agency would undertake to better serve older Americans.

One of the task forces assigned to review special educational needs and make policy recommendations to the Secretary was to be devoted to the older learner. The Secretary subsequently appointed an individual to the Office of Planning and Budget to compile information for the task force on the programs in which older persons can participate, their degree of participation, and how these programs are meeting their needs. This review process was initiated in late 1980, but its continuation will be contingent upon the interest of the Secretary under the new administration.

C. APPROPRIATIONS

Educational programs for older Americans faced the same limitations of a tight budget for fiscal year 1981 as did education programs in general. Below are listed the appropriations for programs which are of particular importance to the elderly, with comparisons between funding for fiscal year 1980 and 1981:

[In millions of dollars]

	1980	1981
Public libraries (services and interlibrary cooperation)	67.5	74.5
Adult education (grants to States)	100.0	120.0
Education information centers (now under title I, HEA)	3.0	3.0
State postsecondary education commissions (now under title I, HEA)	3.0	3.0
University community services and continuing education (now continuing education program and planning under title I, HEA)	9.0	9.
Fund for improvement of postsecondary education	13.5	13.
Community schools	3.1	10.
Consumers education	3.6	3.
Career education	15.0	15.

Adult education, programs of interlibrary cooperation, and community schools enjoyed increases in fiscal year 1981, while other education programs identified as potentially beneficial to older persons managed to hold their own. The final appropriation levels, however, do not reflect the fact that some of these programs—notably the continuing education planning and information services now authorized under title I and career education—were targeted for zero funding or significant cuts in the 1981 Budget and recision requests by the Carter administration. As pressure for spending cuts increases, it seems likely that the Reagan administration may also propose austere budgets for these programs.

D. WHITE HOUSE MINICONFERENCE ON AGING EDUCATION

"Lifelong Learning for Self-Sufficiency" was the theme of the miniconference endorsed by the White House Conference on Aging held in Racine, Wis., on November 12–14, 1980. The miniconference was supported by funds from the Administration on Aging and was cosponsored by the Institute of Lifetime Learning of the NRTA–AARP, the Adult Education Association's Commission on Education for Aging, the Association for Gerontology in Higher Education, and the Population Resource Center.

The miniconference recommendations focused on four areas of self-sufficiency for the elderly in which education plays a vital role:

—Surviving, learning for economic sufficiency.
—Coping, learning for practical life skills.
—Giving, learning for community contribution; and
—Growing, learning to become a fuller human being.

Nine strategies were developed by the conference work groups to strengthen lifelong learning for self-sufficiency among older Americans. These include:

—Empowering older Americans themselves to obtain better responsiveness from institutions, and to meet their own needs, wherever possible.
—Using existing institutions, programs, and resources to provide needed services and support, wherever possible.
—Providing information, counseling and support services.
—Changing negative laws, policies, regulations, or practices.
—Beginning earlier, at midlife or sooner, to prepare individuals for competent and constructive aging.

—Targeting some programs to meet the needs of the disadvantaged.
—Increasing public understanding of the problems and potentialities of older people.
—Conducting relevant research; and
—Alleviating economic barriers to learning for self-sufficiency.

Using these strategies, the delegates to the miniconference pursued the prospects of educational opportunities for older Americans in terms of the four areas of self-sufficiency. Discussion centered on how the public and private sectors can be encouraged to promote work and volunteer opportunities for the elderly, how older persons can be mobilized for service as a vast human resource, and how their coping and life skills can be increased for a lifetime of satisfying competency and productivity.

The recommendations of the miniconference were submitted to the Technical Committee on Education of the White House Conference on Aging, which will issue materials and a report for the use of the delegates to the White House Conference.

E. OUTLOOK FOR 1981

The 1981 White House Conference on Aging, and the emphasis education is given in the Conference recommendations, will be an important indicator of how education for older adults will fare in the 1980's. Rather than have a separate consideration of education at the Conference, as was done at the 1971 White House Conference on Aging, the 1981 Conference will incorporate education in each of the major topics of discussion.

The 1981–82 sessions of the 97th Congress will be taking up the reauthorization of one of our major education programs—the Vocational Education Act. Early in the summer of 1980, the Department of Education developed major policy recommendations for the reauthorization, and some attention was devoted to the implications of the program for older workers, since the act's provisions are aimed at individuals up to age 65. The new administration's plans and proposals for vocational education are uncertain, but the House Education and Labor Committee began oversight hearings in the fall of 1980. The Senate Labor and Human Resources Committee was planning to begin hearings on vocational programs early in 1981. As emphasis on expanding work opportunities for older Americans grows, exploring the ways federally supported vocational education programs can benefit older persons gains importance.

1981 also marks the reauthorization of the Older Americans Act. Many education programs for the elderly are sponsored by senior centers, nutrition sites, and area agencies on aging (AAA's). Organizations representing the elderly and congressional committees are expected to review the impact of these education services on older Americans and particularly how efforts by educational institutions, public, and private organizations can be better integrated to provide older persons the learning opportunities they seek.

The new administration is expected to review the status of the Department of Education with possible changes in mind. These might include reduction of the Cabinet-level Department to a subcabinet agency, similar to the National Aeronautics and Space Administration, or placing Federal education programs within another Department, such as the Department of Labor. Any change in the status of the Department of Education, however, will require congressional authorization.

II. ELDER ABUSE

A. Joint Committee Hearing

On June 11, 1980, the Senate Special Committee on Aging and the House Select Committee on Aging conducted a joint hearing on "Elder Abuse."

The hearing was conducted largely in response to a number of recent studies and reports documenting the physical, psychological, and financial abuse of older people by members of their own families. The major findings of these studies and reports are summarized later in this section.

During the hearing, cochaired by Senator David Pryor of Arkansas and Representative Claude Pepper of Florida, testimony was taken from elderly victims of abuse and experts on the subject.

A typical account of the abuse suffered by many of the victims came from a 79-year-old Massachusetts woman who told the committee about the abuse she experienced from her daughter:

> Several times she locked me out of the house. One of those times it was very cold and snowing with ice on the ground. I had to get to a pay station to call a friend to come and get me. My daughter's treatment of me kept getting worse. Always hurting me physically and mentally; kicking me, pushing me, grappling with me, telling me to get out, at one time throwing a drawer down the stairs at me, calling me names, telling me I belonged in a nursing home and why didn't I go to one. I was not included in family festivities for any of the holidays. She told me I was senile and paranoid and my brain was all shriveled up.[4]

The overwhelming difficulty of combating elder abuse was described by Dean John J. Regan of Hofstra Law School:

> Dealing with the problem of the abused elder presents a classic case of an age-old tension: How to reconcile society's desire to protect its vulnerable citizens while at the same time respecting their civil rights, particularly their rights to liberty, privacy, and autonomy. At stake here are, on the one hand, the State's right as paren patriae to intervene, and, on the other hand, the individual's right to give informed consent to the receipt of social and medical services. Proposed legislative solutions must likewise give attention to the developing constitutional principle that involuntary intervention by government in the lives of its citizens be as little restrictive of liberty as is consistent with legitimate legislative goals and the welfare of the individual.[5]

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[4] U.S. Congress. Senate and House. Senate Special Committee on Aging and House Select Committee on Aging, joint hearing on "Elder Abuse," June 11, 1980, Washington, D.C., pp. 17-18.

[5] Ibid., p. 56.

As a part of its preparation for the joint hearing on "Elder Abuse" which was held with the House Select Committee on Aging, the Senate Special Committee on Aging prepared a summary of the findings of several studies and reports regarding elder abuse and its causes. These findings were published in the hearing record of June 11, 1980, and are reproduced below.

In addition, the Senate Special Committee on Aging conducted a survey to determine how many States have adopted adult protective services laws as a means of coping with elder abuse. The results of the survey, which also explored a number of other issues related to elder abuse, are also included in the following section.

B. ELDER ABUSE: AN OVERVIEW

I. NATURE OF THE ABUSE

LACK OF INFORMATION

There are no statistics to document the scope of parental abuse by adult children, however, findings of a recent report conducted by the University of Maryland tend to suggest that elder abuse occurs less frequently than spouse abuse but as frequently as child abuse (600,000 cases a year on the average). After completing a 1979 study on elder abuse, Dr. Richard Douglas with the University of Michigan Institute on Gerontology concluded that maltreatment of the elderly is a real and complex problem about which too little is known and too little is being done.

MOST ABUSE IS DONE BY RELATIVES

Abusers are most often relatives of the abused. (Block, Marilyn R. and Sinnot, Jan D., "The Battered Elder Syndrome," College Park, Md., University of Maryland Center on Aging, November 1979.)

MOST VICTIMS ARE WOMEN

In general, the abused elder appears to be severely disabled, older than average (75+), middle-class woman who is psychologically abused by her own relatives in spite of attempts to end the abuse by seeking help through normal channels. Anecdotal accounts suggest that the abused felt trapped in their situation. (Block, Marilyn R., "The Battered Elder," page 80.)

ELDER ABUSE: A RECURRING EVENT

A study undertaken in Massachusetts by Legal Research and Services for the Elderly found that elder abuse is a recurring event—70 percent of the surveys returned to those conducting the study indicated that abuse occurred more than twice. Further, 40 percent of the victims often received visible injuries. (Berman, James, et al., "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals," Legal Research and Services for the Elderly, June 1, 1979.)

ELDER ABUSE LIKELY TO INCREASE

Situations where an older person is abused by family members are likely to increase as greater numbers of parents age and require care from their children. Decreasing fertility and mortality rates mean that there will be more older persons and fewer children available as possible caretakers. The adult child may be faced with as many as two sets of grandparents to care for, as well as aging parents. Further, increased divorce rates increase the likelihood that the caregiver will be providing the care without the financial or other assistance of a spouse. (Block, Marilyn R., "The Battered Elder," page 93.)

THREE ASPECTS OF ABUSE/NEGLECT: PHYSICAL, PSYCHOLOGICAL, AND FINANCIAL

The aforementioned Massachusetts study concluded that in 75 percent of the abuse cases cited, the abuser lived with the elderly person who was victimized. The abuser was a relative of the elderly victim in 84 percent of the citings. Other abusers may include staff or operators of foster homes, nursing homes, mental hospitals, etc. In other cases, mental or physical deterioration may result in older persons being unable to care for themselves on a day-to-day-basis. Hence the abuse under discussion here, may be inflicted by: relatives, paid caretakers, or the individuals themselves.

The kinds of abuse or neglect identified by researchers can be categorized as: physical, psychological, or financial/legal (misuse of assets, etc.).

Findings vary as the most frequent kind of abuse. While the University of Maryland study found that psychological abuse occurred most frequently, a study conducted by Elizabeth Lau at the Chronic Illness Center in Cleveland, Ohio, found that physical abuse was the most frequent. Lau found that almost three-fourths of the abuse studied involved physical abuse and over half involved psychological abuse. Further, the elderly clients in the study generally suffered from more than one kind of abuse.

ELDER ABUSE JUST ONE COMPONENT OF FAMILY VIOLENCE

While information about elderly abuse is only now becoming available, recent studies on child abuse and spouse abuse indicate that abuse of the elderly is only one component of a larger problem; family violence. One expert on the subject has written that: "* * * the family is by far the most physically violent group or institution, except for the police or military at war." (Dr. Murray Straus, quoted in Jones, Jean Yarvis and Fowler, Jan., "Child Abuse: History, Legislation, and Issues," Congressional Research Services, Library of Congress, Washington, D.C., December 19, 1979, page 26.)

PROTECTIVE SERVICES: A TWO-HEADED CREATURE—PART SANTA CLAUS AND PART OGRE

In some instances, a mentally or physically infirm elderly person, who may fear the social worker or reprisals from a caretaker, refuses to accept essential medical, social, or other services. Since, unlike a child, an adult is competent until adjudicated otherwise, such a refusal may result in the need for legal intervention in order to authorize necessary protective services. This legal intervention could include guardianship, conservatorship (guardian of property), power of attorney, protective placement, or court-ordered services. This intervention also raises vital questions as to how much control society should exert over personal liberties:

> On the one hand are the ideals of personal choice, individual freedom, the respect for individual freedom, and the respect for individual differences. On the other are the principles that society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations. (Regan, J. J. and Springer, C., "Protective Services for the Elderly." U.S. Senate, Special Committee on Aging, "Protective Services for the Elderly: A Working Paper," Washington, D.C.: GPO, 1977, page 12.)

Not only do some victims refuse to acknowledge the problem, but many professionals who want to intervene cite a lack of legal protection for themselves and for victims, as well as a lack of shelters, funding services, and other resources.

STUDY STRESSES THE NEED FOR LAW

A 1977 report prepared by Prof. John J. Regan, then with University of Maryland Law School, and Georgia Springer, staff attorney, Legal Research and Services for the Elderly, National Council of Senior Citizens, cited the "* * * glaring need for reform of State laws concerning civil commitment, guardianship, and protective services." (Regan, J. J., "Protective Services for the Elderly," page 13.) It may be that the failure of States to reform laws (or to even address the problem at all) stems from circumstances similar to those encountered by the advocates of child abuse legislation: A reluctance to admit that the problems exist:

> Ironically, it may very well be the abhorrence of child abuse which has made it such a slow-moving area of both Federal and State legislation. The very idea that a parent, who is supposed to love and protect his offspring, could be responsible for his or her child's injury, or even death, is so repulsive that many are reluctant to believe it. (Jones, Jean Yavis and Flower, Jan, "Child Abuse," page 1.)

II. CAUSES OF ELDER ABUSE

STUDIES STRESS NEED FOR COMMUNITY-BASED SUPPORT SERVICES

Burston (1975) views battering of the elderly as a natural consequence of inadequate services to families who need support for caring for older family members. (Block, Marilyn R. and Sinnot, Jan D., "The Battered Elder Syndrome," College Park, Md., University of Maryland Center on Aging, November 1979, page 80.)

The need for community-based services was also highlighted in a recent study on guardianship funded by the Administration on Aging. The study, issued in December 1979, stated:

> The need for guardianship is clearly related to the extent and quality of protective services. Given unlimited resources, most elderly now declared in-

> competent and institutionalized could be maintained in the community, particularly with the use of legal mechanisms less restrictive than guardianship (e.g., representative payee). (Schmidt, Winsor, C., et al., "Public Guardianship and the Elderly." Tallahassee, Fla., Florida State University Institute for Social Research, December 1979, page 121.)

In a similar vein, a recent Massachusetts study found that preventive strategies most often recommended by professionals and paraprofessionals surveyed included referral to social service agencies, counseling, arrangements for in-home services, and removal of the victim from the abusive situation. (Bergman, James, et al., "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals," Legal Research and Services for the Elderly, page 2.)

Again, a 1977 study on protective services conducted for the Senate committee concluded that "* * * many tragedies might not occur if legal processes were geared to the task of obtaining support and services for elderly clients before they are forced from their homes." (Regan, J. J. and Springer, C., "Protective Services for the Elderly." U.S. Senate, Special Committee on Aging, "Protective Services for the Elderly: A Working Paper," Washington, D.C.: GPO, 1977.)

STRESS APPEARS TO BE CAUSE

"Like other abused dependents, elders are most often repeatedly abused by family members suffering from stress." (Block, Marilyn R., "The Battered Elder" page 80.)

ABUSIVE PERSON MAY ALSO BE OLDER AND UNDER GREAT STRESS

A study conducted in Cleveland, Ohio, found that as lifespans increase, caregivers who are themselves elderly, are more common. Community resources are generally less available to the elderly person cared for by family than to the isolated individual alone in the community. The result is often unrelenting stress of constant responsibility placed upon or accepted by a relative malequipped by personality, other responsibilities, skill, age, or financial resources, to successfully cope with the task. (Lau, Elizabeth E., "Abuse of the Elderly by Informal Care Providers: Practice and Research Issues," Chronic Illness Center, Cleveland, Ohio, November 20, 1978, page 10.)

UNEMPLOYMENT APPEARS TO BE ASSOCIATED

A major stress-producing condition within society is unemployment. This is supported by child abuse literature which indicates that nearly half of the fathers of abused children were not employed at some point during the year preceding the abusive act and 12 percent were unemployed at the actual time of the abusive act. (Block, Marily R., "The Battered Elder," page 12.)

MULTIPLE RESPONSIBILITIES

Persons who found caretaking difficult were often trying to meet the needs of their spouse and children, as well as the needs of the older relative. (Block, Marilyn R., "The Battered Elder," page 50.)

SUDDENNESS OF NEED FOR CARE

The extent of the conflict was largely dependent on whether the needs of the elder person increased slowly or rapidly. A sudden need for care is likely to cause greater tension, since the caregiver does not have an opportunity to prepare. (Block, Marilyn R., "The Battered Elder.")

AGEISM

Ageism—prejudices or negative feelings toward old age are prevalent in industrialized urbanized societies. These societies exclude the aging from continuing participation and contribution and subtly raise barriers to the availability of resources and services required:

> If we can * * * make life more fulfilling, more positive for the old so that they remain competent, companionable beings, we will certainly reduce considerably the number of elderly parents who are knocked down or verbally battered by their own exhausted children. (Block, Marilyn R., "The Battered Elder.")

PERSONALITY CONFLICTS, ROLE DEFINITIONS, AND PROBLEMS WITH COPING

Further, conflict between mothers and daughters have been discussed in terms of personality conflicts which were worsened by the passing of years and failure to redefine family roles can result in either latent hostility or possible overt violence. It has also been suggested that conflict between family members and the aged is most likely in situations where family members, either individually or as a family unit, have difficulty coping or if the parent is suffering from a chronic disease. (Block, Marilyn R., "The Battered Elder," page 11.)

ALMOST NO ONE IS IMMUNE

One researcher believes that almost no one is immune to the role of the abuser, if the discrepancy between situational demands (older person's problems, stress on caregiver) is great enough, although people vary in the degree to which they are prone to act in an abusive manner.

C. SURVEY OF STATES ON PROTECTIVE SERVICES AND OTHER ISSUES

INTRODUCTION

The Senate Special Committee on Aging in March 1980, contacted all Governors and State legislative committees on aging to obtain information on adult protective services laws and a number of related issues. The following is a list of questions contained in the letter and a statement as to why they were asked:

1. THE NUMBER OF STATE ADULT PROTECTIVE SERVICES LAWS

Question: Does your State have a protective services law or has legislation creating such a law been introduced? If an elderly person in your State will not consent to the provision of protective services, what legal authority, if any, exists for requiring the person to accept protective services or protective placement. For the purposes of this question, protective services are services furnished to an elderly infirm, incapacitated, or protected person with the person's consent or appropriate legal authority, in order to assist the person in performing the activities of daily living, and thereby maintain independent living arrangements and avoid hazardous living conditions.

Explanation: As indicated earlier in this document, recent studies indicate that elder abuse may occur as often as child abuse. The fragmented information available on the topic indicates that States are responding to the problem by enacting adult protective services laws. The first question was designed to determine which States have enacted such laws.

2. THE PORTION OF OLDER PERSONS IN STATE MENTAL HOSPITALS

Question: How many persons are residing, either voluntarily or involuntarily, in your State mental hospitals? What percent of these people are over the age of 60? What percent of these elderly people could be returned to the community if appropriate support services were available?

Explanation: Protective services workers indicate that one of the major obstacles to dealing with elder abuse is finding appropriate placement for a person who must be removed from a dangerous situation. Too often the only alternatve is some form of institutional care.

Generally, the problems faced by protective services workers and courts are not unlike those faced by families and social workers in trying to place an older person who may be experiencing mental or physical deterioration. These difficulties with placement were explained in a 1977 report prepared for the Senate Special Committee on Aging. The report, entitled "Protective Services for the Elderly," discussed placement of older persons in institutions:

> Although most communities have resources for helping the elderly with mental and physical infirmities, they have been slow to respond sufficiently to the needs. This tardiness has exacted a terrible price in human tragedy, not to mention the exorbitant economic loss to the individual and to society.
>
> The human cost is seen in the appalling condition of the victims. Neglect of the aging person leads to withdrawal, increasing disorientation, mental

disturbance, and physical deterioration. For those living in need of care, there is a constant threat of injury from fire, assault, or accident.

At the same time, the elderly who are beneficiaries of social services may be at even higher risk of injury or death. When the elderly receive that attention, this may mean that the social workers and courts will put the client in an institution where both the enjoyment and length of life are curtailed. In addition to a shortened life, confinement in an institution usually means loss of self-esteem, of freedom, and of useful activity.

For families and spouses, especially those without much money, the burden of caring for a disabled older person can be exhausting emotionally, financially, and physically. It is as painful to see a loved one decline as it is difficult to meet their needs, whether or not assisted by community resources. Yet the family often finds it even more heartbreaking to commit the patient to an institution.

Present public policies of relying primarily on institutional care without providing other options are as damaging to society as to the individual involved.

Noninstitutional alternatives in long-term care are drawing increased attention at the local, State, and Federal level, as they play a crucial role in either keeping people out, or assisting with the removal of people from institutions.

In response to studies indicating that the elderly compose a large percent of those confined to mental institutions, coupled with the growing interest in alternatives in long-term care, the States were asked about the portion of elderly residents in their mental hospitals and about possible placement in the community.

3. LICENSURE OF SMALL, HOMELIKE FOSTER CARE RESIDENCES

Question: Are there any small, homelike foster care residences for adults in your State? If so, does your State have a law licensing, certifying, or in anyway regulating these foster homes? Are there foster homes only regulated when they serve more or less than a certain number of people? If so, please elaborate.

Explanation: This question was asked because homelike residences are an important form of community-based care in some States.

4. APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT

Question: In your opinion, what should be the Federal role in protecting older people from abuse or dangerous circumstances caused by their own mental or physical decline?

Explanation: Because the elder abuse being explored by the committee occurs within the confines of the family, the Federal Government must be mindful of individual and States' rights in trying to deal with the problem. As stated in the working paper on protective services, cited earlier, protective services laws that have been enacted by a number of States are part Santa Claus, part ogre:

> On the one hand are the ideals of personal choice, individual freedom, and the respect for individual freedom, and the respect for individual differences. On the other are the principles that society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations.

Aside from the question of individual rights, is the issue of States' rights. How can the Federal Government best proceed without circumventing the authority of the States?

State Responses Cataloged

I. STATE PROTECTIVE SERVICES LAWS

Before discussing the responses to the first question, it must be pointed out that adult protective services laws vary tremendously in scope. There is no clear guideline establishing what must be contained in a statute, or statutes, before a State can say it has an "adult protective services law." The committee attempted to compensate for the absence of a specific guideline by including a definition in its first question. In reading this section, it should therefore, be kept in mind that it simply catalogs the States' responses based on the committee's definition (see Introduction).

A. *Half of the States Have an "Adult Protective Services Law"*

Responses indicate that half (25) of the States have what the respondents consider an adult protective services law.

Different States, is should be noted, protect different people. Kansas, for example limits the provision of protective services to people in nursing homes or medical facilities operated by the State or Federal Government. Other States cover abuse or neglect of adults who live in the community.

In addition to the 25 States that have adult protective services laws, at least two, Nebraska and Minnesota, have laws that only require the reporting of abuse. No provision is made for the delivery of services. Other States have laws authorizing the provision of services, but do not require reporting.

The master chart, which follows, identifies which States indicated they have protective services laws and contains some descriptive information, as well.

B. *Most Laws Passed in the Last 5 Years*

The respondents were not asked when their State's adult protective services law passed. But, most volunteered the information. At least 16 of the laws were passed in the 5-year span from 1976–80; no fewer than 8 of these in 1977 alone.

C. *Bills Before Many State Legislatures*

Of the States without adult protective services laws, 14 have had adult protective services bills sponsored in their State legislatures, and 4 indicated that legislation is being developed.

II. THIRTY PERCENT OF THOSE IN STATE MENTAL HOSPITALS ARE ELDERLY

About 30 percent, 43,365 of the approximately 145,050 people in State mental hospitals, are elderly. Elderly in this case means age 60 or over. It is likely that it is a conservative estimate, because several States were only able to provide the committee with information on the residents age 65 and over.

It should also be noted that the figures provided the committee were not based on the population of State mental hospitals on one specific date or month. The time frame during which the figures were collected varies by a period of up to several months. Consequently, these figures should be viewed as estimates.

Not surprisingly, the percent of older people in State mental hospitals varies greatly: from a low of 1–3 percent in Alaska to approximately 50 percent in Pennsylvania and Virginia.

The portion of elderly residents who could be discharged if appropriate services were available varies still more: From almost no one in Wisconsin—which has long emphasized community-based mental health care—to almost all elderly State hospital residents in other States.

III. VAST MAJORITY OF STATES LICENSE SMALL, HOMELIKE FOSTER CARE RESIDENTS

As the master chart indicates, almost all States have laws requiring the licensure of small, homelike foster care residences for adults. While the name for this kind of facility varies from State to State, they are usually licensed under laws that are specifically developed for homes serving fewer than anywhere from two to five people.

IV. THE APPROPRIATE FEDERAL ROLE

Generally, the most frequent response indicated that the Federal Government could be most helpful by providing additional funding for the implementation of State protective services programs. In many cases, the importance of increase title XX funding was stressed.

The respondents also stressed the need for the Federal Government to encourage—or even mandate—States to enact protective services laws.

The need for information and training in the area was frequently mentioned, and suggestions were also made for policy changes.

The following outline summarizes States' comments on the appropriate Federal role. It is interesting to note that many of the comments are equally applicable for State government action.

Response	*States*[1]
I. Need for money:	
A. To fund protective services programs in States	8
B. To expand other in-home services	3
C. To create shelters	2
D. To fund research and demonstration projects	1
II. Need for State protective services laws:	
A. Encourage States to develop protective services legislation	3
B. Mandate States to develop and enact protective services legislation	5
C. Specifically mentioned national approach similar to that used in child abuse	2
D. Develop model protective services legislation	4
E. Establish uniform guidelines or standards for the provision of protective services	3
III. Need for information:	
A. Federal Government to provide technical assistance/training	4
B. Federal Government to establish clearinghouse	3
C. Need to educate public	2
IV. Policy changes:	
A. Allow title XX to offer services on an emergency basis for a limited time, regardless of income	1
B. Expand rights of elderly boarding home residents to be as broad as nursing home residents (i.e., ombudsman program)	2

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[1] Number of States giving this response.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Alabama	Yes. Passed in 1977		2, 384	20 (476 people)		Establish standards and provide funding to enable the States to develop programs to prevent elder abuse through public education, outreach, and enforcement.	No homes/no laws	
Alaska	No		235	About 2 (5 people)	70 (2 people)	Provide technical assistance.		
Arizona	Yes. Passed in 1980		300	40 (120 to 125, people)	20 (about 80 percent would be in nursing homes)	Provide funding for protective services programs.	License foster homes which may not have more than 5 people.	
Arkansas	Yes. Passed in 1977		266	9 (25 people)		Expand medicaid regulations provisions for advocates and ombudsman to boarding homes and other residential settings.		
California	No. No comprehensive law at this time.	Conservatorship law with due process provisions enacted in 1977.	5, 314	9.7 (516 people)	Not known	Until authorities determine what is wisest way to treat elder abuse, it is difficult to determine which level of Government should take action.	License 4,207 "small family homes for adults" for people needing some care and supervision.	
Colorado	No. 1980 reporting bill introduced, but was not passed due to lack of funding.		984	11 (108 people)	Approximately 50 (60 people).	Develop legislation to insure "uniform provision of services" to abused elderly.	License homes from 1 to 15 people. State and counties supplement payments.	
Connecticut	Yes. Passed in 1978	If won't accept services, a conservator is appointed.	2, 211	14 (314 people)	Not sure, but figure it would be substantial.	If anything, mandate that States develop some system for responding to elderly abuse.	License any facility that houses 2 or more elderly persons and provides more than room, board, and laundry.	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Delaware	No		[1] 519	22 (114 people)	Only because 3 have a well-developed foster care program.	Gather and disseminate statistics and documentation of older people living in dangerous circumstances. Provide additional money for public advocacy in OAA for protective services.	Yes. Only those that serve 1 person are exempted.	
Florida	Yes. Passed in 1977		5, 174	30 (1,527 people)	No information on 60 plus, but by July 1980, expect to refer 46 percent of 55 plus patients for discharge.	Provide funding to encourage States to develop protective services program through programs like title XX.	License foster homes and adult congregate living facilities.	Community based State programs fo elderly in Florida include: (1) Home care, pays family friend to care for elderly; (2) ''Com munity care for eiederly'' to pay f services like respi care, day care, tra portation.
Georgia	No. Bill introduced, but not reported by House Judiciary Committee.	Unless can find a guardian cannot intervene on behalf of older person—guardianship statute revised in 1980—Department of Human Resources may be guardian.	5, 569	21 (1,175 people)	25 to 50. An additional 35 percent if nursing homes considered appropriate.	Make sure Federal laws and regulations don't interfere with a person's rights. Cites legislation empowering U.S. Attorney General to intervene when nursing home residents' rights are violated as superb.	License homes according to size.	
Hawaii	No. Legislation introduced in 1975 but did not pass.	----------------------	255	10 (22 people)		Legislate mandatory minimum standards for States in provision of protective services. Provide for research and training grants, as per child abuse.	License homes according to number served (4 is break-off number for various homes).	

	No. Draft legislation developed but not introduced.	Have a "progressive" guardianship law.	232	22 (51 people)	36 (8 people)	Direct Department of Justice to develop model adult protective law.	Have shelter care licensure for facilities caring for 3 or more people.	Have trouble finding guardians for poor people.
Illinois	No. Bill before Illinois Legislature would create special legislative commission to study elderly abuse.	Have a new guardianship and advocacy program, which became effective in 1980.	10,240	7 (685 people) (was 10,000 a decade ago).	Only residents who cannot be cared for in the community are cared for in the hospital.	Encourage examination, review and identification of elder abuse.	Have a small program, only 340 people statewide. VA has about 250 people but there is no licensure law just department standards (Public Health Department).	
Indiana	No. But, commission on aging is working on one.		5,060	17 (865 people)	No answer	Provide for public education.	Have licensure laws for various sized homes.	
Iowa	No. No law or pending legislation.		1,040	22 (228 people)	100	Establish firm criteria in guiding States in protecting adults.	License residential care facilities for 4 or more beds.	
Kansas	Yes. Became effective July 1, 1980. But is limited to people in nursing homes or medical facilities operated by State or Federal Government. Also have protection from abuse act.		[3] 1,200	Approximately 10 (120 people).	95 percent could return, depending on definition of support services.	Develop model legislation on abuse reporting and hearings to show that the problem exists. Promote a program for alternate living arrangements.	License: "1-bed adult care homes" as well as "2-bed" homes. Also license boarding homes for 3 or more people.	Abused adult can either seek redress under criminal statutes or from "protection from abuse act" if they are abused by a family member.
Kentucky	Yes. Enacted 1976, revised 1978 and 1980. The law requires reporting and provides for emergency services for those who can't care for themselves.		789	20 (157 people)	33	Set standards and encourage States to enact adult protective services laws.	Have "family care homes." Require licensing if care for 2 to 3 people. If 3 or more are licensed as personal care homes.	
Louisiana	No. But a bill is before the legislature.		2,093	15 (317 people)	No answer	Develop national clearinghouse for elder abuse information. Fund protective services programs. Designate people on national and regional levels as consultants.	No	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Maine	Yes. Involuntary protective services must be provided through public or private guardianship.		630	40 (252 people)	32 to 38.2 percent could be returned according to a study.	Fund and require State protective services laws.	Adult foster home program licenses homes for 4 or fewer people.	
Maryland	Yes. Became effective in 1977.		3,637	36.3 (1,320 people)	38 (23 percent in nursing home, 15 percent in family setting).	Federal Government should require all States to enact guardianship laws.	No statewide licensure program, but counties do license, though standards vary.	
Massachusetts	No. Legislation before legislature, but already have a law "dealing with prevention of abuse in general."		[3] 2,000	30 (600 people)	Very few	Should fund more for title XX. The Federal Government should act as a clearinghouse for information on elder abuse.	Have some facilities and these are subject to State building codes.	
Michigan	Yes. Act No. 136 of the Public Acts of 1976 and sec. 68 of 1978–79 Appropriations Act. Bill in 1980 would require reporting, confidentiality and immunity.	New probate court code and mental health code gives probate courts the authority to appoint guardians and conservators of adults who are unable to manage finances.	[3] 4,807	16 (759 people mentally incompetent).	28.1		Have 3,012 adult foster care facilities licensed to serve 18,836 people.	Goal of guardianship and mental health law is to maintain person in least restrictive setting.
			[4] 4,974	3 (151 people mentally retarded).	26.9			Law does not require reporting.
Minnesota	Reporting law only. Sponsored for first time and passed in 1980.		4,893	8 (387 people)	1 or 2 people, if any	Develop a national policy for dealing with adult abuse. Make sure that all agencies working on the problem coordinate work.	No State licensure law in foster-type homes.	Minnesota has been working on deinstitutionalizing its mental hospitals since the mid-1950's. Will soon be closing one, and possibly more.

Mississippi	No. Bill introduced in 1980 but not reported out of committee.		2,285	39 (891 people)	60 percent with nursing homes 10 to 15 percent without.	Funding of protective services. Set minimum "care" standards to apply in the absence of State law.	No licensure of boarding homes, thoug they exist. No foste care-type homes. D license personal car homes.
Missouri	Yes. Passed in 1980. Consent required for the provision of services, unless a person is first declared incompetent.	No legal right to intervene against a person's wishes.	[illegible] 2,631	26.7 (704 people) 8 (29 people of those in mental health centers)		More emphasis should be placed on prevention. Need more money for rural health needs.	Bill before legislatur would pay relative to provide foste care.
Montana	Yes. Statute does not define abuse, exploitation, neglect, etc. Does not have a reporting provision.	Use guardianship law to provide protective services involuntarily, use public or private guardians.	514	31 (218 people)	13 (67 people)	Support budget requests for title XX protective services and require States to pass model protective services legislation.	License for 4 or more people.
Nebraska	Has a reporting law, but services to be provided are in directives issued by Division of Social Services, not in law.	Cannot provide services involuntarily.	582	13 (76 people)	Respondent said question is "moot."	Change title XX to allow social services to be provided without regard to income on an emergency basis for a limited time (90 days). Require resources to be coordinated.	Have 260 licensed adult family home Have 26 custodia foster homes with 849 beds for more structured environment.
Nevada	No. Bill introduced in 1979, but did not pass. Bill dealt with people over 18.		152	12 (17 people)	Not applicable. State hospital beds are for acute/crisis care only. Don't have chronic back-ward patients.		No licensure law. But welfare division certifies homes that care for 3 or more people who receive State SSI supplements.
New Hampshire	Yes. Enacted in 1977. Must petition for guardianship or temporary guardianship to provide involuntary protective services.		782	32 (251 people)			Regulate all homes that provide care or supervision to adults; but not those that provide room and board.

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship aws	Number of people in mental hospitals	Percent of these elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
New Jersey	No. A reporting bill is being reviewed by the Assembly.		3,929	42 (1,645 people)			New law requires that boarding homes, rest homes, or other homes for the sheltered care of 4 or more adults be subject to State regulation, approval and inspection. But, have no small homelike foster care residence for adults.	
New Mexico	No. Bill sponsored in 1979, but did not pass.	Provision in probate code is only legal authority for providing adult involuntary protective services.	237	27 (64 people)	10	Should mandate and fund same protection for adults as for children.	No foster care exactly but have many adult residential shelter care and boarding homes with 6 or fewer residents.	
New York	Yes. In 1979 it was expanded to cover all individuals incapable of managing themselves, not just SSI recipients.	A recent "State task force on protective services for adults" targeted involuntary intervention as one of the major areas for study. Now can't provide services to someone who won't accept them, but legislation is pending.	25,041	53 (13,288 people)		Strongly emphasize protective services in Federal legislation. Fund protective services with local and State flexible allotment.		Not sure should go route of child abuse act, because not sure of program's value. Therefore, go with demonstration programs first. Mentioned the importance of housing and home services in solving problems.
North Carolina	Yes. Contains reporting provision.		3,375	35 (1,181 people)	75 to 80	Eliminate title XX ceiling.	License family care homes for 2 to 5 people.	
North Dakota	No. Agency personnel are working on a draft bill.		564	34 (192 people)		Needs to take an active role as in child abuse. Do national conference on topic.	Have a licensure law but not a well established statewide foster care program.	
Ohio	No. Bill before legislature now, but was not passed due to gap in coverage, which left the 18–54 yr. olds uncovered.		11,074	20 (2,106 people)			License foster homes for not more than 5 people, at least 1 who receives SSI. Group home for 6 to 16, licensed, at least 1 on SSI.	

Oklahoma	Yes. Law passed in 1977. "Elderly" person is defined as someone 65 or older. Authorizes involuntary protective services with a court order, if person lacks capacity to consent to services and is suffering from abuse, neglect, or exploitation presenting a substantial risk of death or immediate serious harm to himself.		1,518	26 (392 people)	Not known.	Federal role should be providing grants to States to study the problem and implement requirements based on State need.	No law has been implemented due to lack of funding and documentation of need.	
Oregon	Yes. Statutory authority is only 1 sentence long. Simply directs State agency to develop regulations for the provision of "social services, including protection, to those individuals in need of, or who request such services."	Guardianship, etc., may be used to provide protective services without consent.	1,192	6.9 (have been stressing community placement) (82 people).	2	Encourage States to develop comprehensive protective services programs. Increase title XX funding for protective services.	Has 850 certified adult foster care homes, for 5 or fewer people.	State is currently researching possibility of establishing a social service system to serve abused elderly.
Pennsylvania	No. But several bills introduced. Now provide protective services to people involuntarily through mental health procedures act or incompetent estates act.		10,500	50 (5,250 people)	No answer, but currently discharge less than 1 percent of people over 60.		State has a domiciliary care program, certified by area agencies on aging for SSI recipients. Are also 30 county-operated foster homes for those residents who are usually healthier than domiciliary care.	
Rhode Island	Yes. Provide protective services only on voluntary basis. Reporting bill filed in 1980, as was legislation creating limited guardianship and conservatorship.		666	19 (127 people)	15 to 20 people		Have no group homes just for the elderly, but all group homes are licensed.	
South Carolina	Yes		3,550	43 (1,537 people)	28 (427 people)	Conduct workshops in States that don't have protective services laws. Develop model legislation.	Adult residential facilities and licensed for 2 or more.	
South Dakota	Yes		457	40 (183 people)	50		License 183 facilities	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Tennessee	Yes. Passed in 1978. Applies to anyone 18 or over, who because of mental or physical dysfunctioning or advanced age (60 plus), is unable to care for self (paraphrased).	Court can order that services be provided involuntarily in life threatening situations. Requires that the person have counsel.	2, 218	39.5 (895 people)	5		Depending on kind and size of home, have a variety of licenses, starting with homes with 1 or more unrelated people.	Also have State homes operated by department of Human Services and licensed by Department of Public Health.
Texas	No. But several bills have been introduced.		1, 518	27.48 (417 people)		Provide funding	License approximately 200 foster family care homes with up to 3 people. Homes with 4 or more are licensed as long term care.	
Utah	Yes. Has a law (since 1977) that spells out provisions for assisting elderly people who will not consent to provision of protective services.		310	16 (50 people)	50 (25 people)	Provide funding. Also provide consultive services and act as a clearing house for information and training.	Do not license, but certify and approve adults foster homes for up to 3 people.	
Vermont	Yes. Law passed April 1980.		286	29 (83 people)	45 total people. 15 people to nursing homes. 30 people to other settings.	Educate country about problem. Mandate that each State enact protective services legislature.	License "community care homes."	
Virginia	Yes. Passed 1977		4, 876	49.9 (2,433 people)	25 (608 people)	Encourage States to enact protective services laws. Establish national policy for continuance of in-home services. developed in concert with voluntary sector. Simplify coordination by medical and social services and case management. Channel money away from institutions to community-based care. Initiate national public awareness effort.	License homes for 4 or more people.	

Washington	No	Can provide supportive treatment under: Guardianship (also limited guardianship); involuntary commitment; reporting and investigation required of nursing homes.	3,950	9.3 (371 people)	[6] 18.7	Housing: Assist in creation and funding of shelter facilities. Training of adult protective services staff and care givers of abused adults. Research-demonstration projects.	License adult family homes that serve a maximum of 4 people. There are 400 homes, 235 of which have a contract with State.	
West Virginia	No. Bills introduced for past 5 years, but since Department of Welfare can provide service it thinks is necessary, it has issued guidelines for delivering protective services.	No agency has authority to provide services involuntarily (has been very controversial issue in legislation).	2,724	28 (623 people)	Not sure	Require States to pass protective services law, which should require that a lead agency be designated.	Has 780 approved adult family care homes for 1 to 3 elderly people.	Have trouble recruiting adult family care homes because reimbursement is so low ($195 to $265) per month.
Wisconsin	Yes. Passed in 1973. No reporting provision.	Can only be given services involuntarily if have a guardian, however, may be placed under protective placement if there is a probability of irreparable injury at death.	[2] 500	5 (25 people)	None. Place much emphasis on community mental health care.	Provide flexible block grants, so that States can fund services they think are important.	License adult family homes for 1 or 2 and community-based residential for 3 or more.	Think Federal Government should assist States develop noninstitutional support service. Now availability of funds determines programs, not appropriateness.
Wyoming	No. State is working on preparing one that will deal with abuse of all people, not just elderly.		279	22 (60 people)	25 (15 to 20 people)	Establish a Federal adult abuse registry, develop training sessions and resource material and funding for such projects.	In accordance with the Key's amendment in Federal law (Public Law 94-566) they have established minimum standards for foster homes serving SSI recipients.	

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[1] Also has a 122-bed secure intermediate care facility.

[2] Approximately.

[3] Mentally incompetent.

[4] Mentally retarded.

[5] In addition 350 in mental health centers.

[6] 18.7 percent is as follows: 3.2 percent could be independent. 9.1 percent to congregate care or nursing homes. 6.4 percent could go to residential care if had special mental health treatment.

D. Legislative Followup

When considering the Domestic Violence, Prevention and Services Act of 1980 (S. 1843), on September 4, the Senate adopted an amendment offered by Senator John Heinz of Pennsylvania, to fund a study on the nature and incidence of elder abuse. The study was to have been conducted by the Secretary of the Department of Health and Human Services and delivered to Congress within 18 months, along with any recommendations deemed appropriate.

While the House approved a conference report that worked out differences between the House and Senate versions of the domestic violence legislation, the Senate never acted on the compromise. As a result, the legislation died when the 96th Congress adjourned in December.

Representative Mary Rose Oakar of Ohio introduced H.R. 7551 on the same day as the aforementioned joint hearing on "Elder Abuse" (June 11, 1980). Her bill would create a National Center on Adult Abuse and provide financial assistance for programs for the prevention, identification, and treatment of adult abuse, neglect, and exploitation.

H.R. 7551 would establish a National Center on Adult Abuse similar to the National Center on Child Abuse and Neglect and the Office of Domestic Violence. This center would compile an annual research summary, act as an information clearinghouse, provide technical assistance, conduct research, and award grants for demonstration or service programs and projects.

H.R. 7551 was referred jointly to the Committees on Interstate and Foreign Commerce, and Education and Labor, but was not considered by either committee before adjournment of the 96th Congress.

III. FOOD STAMPS

The second session of the 96th Congress began and ended with notifications to the Congress by the Secretary of Agriculture that the food stamp program was in financial trouble and benefits would have to be terminated for several months unless supplemental appropriations were approved. Plagued by soaring food prices and expanding benefit rolls due largely to a higher rate of unemployment, the program's spending caps for both fiscal years 1980 and 1981 had to be legislatively increased.

The eligibility rolls increased to 22 million persons by the end of 1980. Of these 22 million, the U.S. Department of Agriculture (USDA) estimated that approximately 7.6 percent or 1.7 million persons, were aged 60 and over. Early USDA figures on enrollment data after the elimination of the purchase requirement (amount previously charged for coupons) show that elderly participation increased approximately 32 percent as compared to 14 percent for nonelderly recipients. This increase in elderly participation was attributed to the elderly's inability to buy their way into the program in the past when a substantial amount was required to purchase the coupons.[6]

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[6] Public Law 95–311 enacted in 1977 eliminated the purchase requirement. However, final regulations governing this change were not issued until late 1978 and 1979 and, therefore, descriptive data on the impact are only now being collected. A more detailed USDA report on the impact of eliminating the purchase requirement is expected in February 1981.

A. FOOD STAMP AMENDMENTS OF 1980

The Food Stamp Act Amendments of 1980 (Public Law 96–249) were signed into law on May 26, 1980. Major provisions of the new amendments included increasing the spending cap to $9.49 billion for fiscal year 1980 and $9.7 billion for fiscal year 1981. Modifications aimed at curtailing food stamp spending increases were also added.

Changes in the food stamp program affecting elderly participants are described below:

—Public Law 96–249 eliminates the twice-a-year cost-of-living increases in the benefit levels, standard deduction and the excess shelter deduction, and authorizes an annual increase to be adjusted in January of each year.

—The law reduces the assets limitation from $1,750 to $1,500 per household *except* for households with two or more persons with an elderly person whose limitation shall remain at $3,000.

—States have the option of determining program eligibility on a retrospective rather than prospective basis. This option allows the food stamp office to use one's previous month income for determination instead of income estimated for upcoming months, which will assist States in reducing the error rate in benefit and eligibility determinations and thus save dollars.

—Recipients are allowed to disregard income received as energy assistance payments as countable income.

—The law exempts vehicles used for transporting physically handicapped individuals from being counted as assets.

—The special medical deduction for elderly persons is expanded by allowing persons 60 and over and the disabled to deduct all allowable medical expenses above $25 a month when determining their net income for program eligibility and benefit level. The special deduction was also expanded to cover medical expenses of spouses, regardless of age or physical condition.

—Households whose members are all recipients of SSI can apply for participation in the food stamp program by filling out simple application forms in local or district Social Security offices.

—The 1980 amendments require disclosure of certain information regarding taxes from the Social Security Administration and unemployment offices to the USDA and State food stamp offices to determine food stamp eligibility.

—Several provisions are included in the new law which provide incentives for States to reduce their error rate and thus save millions of dollars. In addition, penalties are prescribed for States which fail to reduce their error rate below the national rate within a given period of time.

B. FUNDING PROBLEMS OF 1980

In 1977, Congress authorized and extended the Food Stamp Act through fiscal year 1981 (Public Law 95–311). At that time, the Congress and administration made projections for the program through 1981 in order to set spending caps for the program.

By early 1980, it was evident that food prices had risen three times higher than projected for 1980 and the unemployment rate of 7 percent was approximately a percentage point above earlier projections.

Therefore, it was crucial for the Congress to provide supplemental appropriations for the program or face the program's inability to provide benefits for the last few months of the fiscal year. In May 1980, Public Law 96-423 provided for an additional $2.6 billion to bring the total available for the program to $8.8 billion. However, by June it became apparent that additional funding would be needed to continue benefits through September 30, 1980. Congress was forced to approve an additional $400 million to the program bringing the total 1980 appropriation to $9.2 billion (Public Law 96-304).

This was not the end. During the final hours of the 96th Congress it again became apparent that the $9.7 billion approved for fiscal year 1981, would be insufficient to cover projected benefits for the whole year. Debate in the Senate resulted in nothing substantial, but it is indicative of the problem which will continue to plague the 97th Congress.

IV. CRIME AND THE ELDERLY

A. The Problem

There is a substantial body of evidence suggesting that the elderly of this country are the least likely age group to be victimized by crime. It is generally recognized, however, that there is a certain distinctiveness about the elderly as crime victims. Various demographic trends in this country project the ballooning of the elderly population over the course of the next 50 years, from 11 percent of the present population to a possible 22 percent of the population by the year 2030.[7] The sheer numbers of older people in the United States demand an examination of this problem and the characteristics of older Americans which set them apart from the total crime picture. Some of these distinctive features include the following factors:

—The economic impact of crime on elderly victims is generally more severe than on younger people. Many older people live on fixed, relatively low incomes, and they have little hope of recouping financial loss through future earnings.

—Older people are more likely to live in high-crime neighborhoods, because of either limited income or reluctance to leave inner-city neighborhoods in which they have lived for so long. The elderly may choose to live at risk in unsafe surroundings because they find the familiar setting comfortable in a world that seems to change daily. Elderly people are also more likely to live alone.

—The natural handicaps of aging make the elderly obvious targets for criminals. Often unsteady and slow moving, they can easily be pushed off balance and fall. Hearing and vision impairments render an older person more susceptible to surprise attack.

—Since older people tend to be concentrated in inner-city neighborhoods, often separated from family members, they rely on public transportation, or walk to carry on the essential tasks of everyday living.

—It is common knowledge on which days social security checks are mailed and received. At this time of the month, seniors are more likely to be carrying around large sums of cash, thereby increasing their vulnerability.

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[7] U.S. Bureau of the Census. "Current Population Reports," series P-23, No. 59, and series P-25, No. 704.

Possibly the best indicator of the incidence of criminal activity is the National Crime Panel, which is a program established by the Law Enforcement Assistance Administration to develop information not otherwise available on the nature of crime and its impact on society by means of victim surveys of the general population. Data collected by the National Crime Panel (NCP) has two distinct advantages over crime statistics compiled by the Federal Bureau of Investigation (FBI). NCP surveys are the only studies of crime at the national level which keep statistics on a uniform basis. The FBI statistics are an assorted accumulation of facts kept by thousands of law enforcement agencies across the country. This makes comparison of raw data virtually impossible because criteria for gathering this information is not uniform. Second, within each locality surveyed, NCP samplings are made of household and commercial establishments representative of the area, in order to elicit information about experiences, if any, with certain crimes of violence and theft. Events that were not reported to the police are included, providing a more complete picture of actual victimization rates.[8]

The victimization studies show that the highest rate of victimization occurs in the young age groups, with each older group having progressively lower rates. Persons 65 and older have the lowest rates, especially for violent crimes such as rape, robbery, and assault, being victimized at a rate of 9 per 1,000 persons age 65 and over. The combined victimization rate for all three crimes for the general population was 34 per 1,000. A summary of the pertinent data from the victimization survey is shown in the following table:

TABLE 1.—PERSONAL AND HOUSEHOLD CRIMES: VICTIMIZATION RATES FOR THE GENERAL AND ELDERLY POPULATIONS

Type of crime	General population[1]			Elderly population[2]		
		Percent change			Percent change	
	1973 rate	1973–74	1974–75	1973 rate	1973–74	1974–75
Personal crimes:						
Crimes of violence	34	+1.5	−0.4	9	+5.5	−13.5
Rape	1	+4.3	−7.1	[3] 2	+66.7	−70.0
Robbery	7	+6.4	−5.6	5	−21.6	+10.8
With injury	2	+.4	−9.0	2	+3.8	−36.8
Without injury	5	+9.6	−4.0	3	−36.7	+57.1
Assault	26	+.1	+1.5	4	+46.0	−30.5
Aggravated	10	+3.3	−7.4	1	+46.2	−6.5
Simple	16	−2.2	+7.8	2	+45.9	−41.8
Crimes of theft	93	+4.2	+1.0	23	−1.9	+11.9
Personal larceny with contact	3	+1.6	−1.0	4	+5.5	−4.9
Personal larceny without contact	90	+4.3	+1.0	19	−3.2	+15.1
Household crimes:						
Burglary	93	+1.3	−1.3	55	−1.2	−1.0
Household larceny	109	+15.6	+1.5	48	+22.5	+1.3
Motor vehicle theft	19	−1.7	+4.0	5	+5.6	+8.6

[1] Rates for personal crimes are per 1,000 persons age 12 and over. Rates for household crimes are per 1,000 households.

[2] Rates for personal crimes are per 1,000 persons age 65 and over. Rates for household crimes are per 1,000 households headed by persons age 65 and over.

[3] Less than 0.5 per 1,000.

Source: U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, 1973 (tables 2, 4 and 16). U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, A Comparison of the 1973 and 1974 Findings (tables 1, 4, 8 and 9). U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, A Comparison of the Findings (tables 1, 4 8 and 9).

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[8] U.S. Department of Justice. Law Enforcement Assistance Administration. "Programs for Senior Citizens," February 1978.

In only one crime category—personal larceny with contact, which includes "street crimes" such as purse snatching and pickpocketing—are older persons victimized at a greater rate than the general population. Additional survey findings of the National Crime Panel indicate that the elderly are slightly more likely to be injured as the result of criminal activity which manifests itself in a higher rate of hospitalizations for persons 65 and older.

TABLE 2.—PERCENT OF VICTIMIZATIONS IN WHICH VICTIMS SUSTAINED PHYSICAL INJURY, BY AGE OF VICTIMS AND TYPE OF CRIME, 1977

Age	Robbery and assault	Robbery	Assault
12 to 15	31.2	24.4	32.9
16 to 19	31.6	33.0	31.4
20 to 24	31.7	40.6	27.1
25 to 34	26.9	41.3	24.3
35 to 49	29.0	31.3	29.3
50 to 64	25.5	31.3	22.5
65 and over	35.3	57.5	26.6

Source: U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, 1977 (table 67).

TABLE 3.—PERCENT OF VICTIMIZATIONS IN WHICH VICTIMS RECEIVED HOSPITAL CARE, BY AGE OF VICTIMS AND TYPE OF CRIME, 1977

Age	Crimes of violence	Robbery	Assault
12 to 19	6.4	6.2	5.8
20 to 34	7.4	10.0	6.7
35 to 49	9.0	7.3	8.8
50 to 64	8.5	7.6	9.0
65 and over	8.1	14.9	2.7

Source: U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, 1977 (table 71).

The data also indicates that there is a positive correlation between increased age and chance of victimization at the hands of strangers. In 82 percent of the surveyed crimes of violence against elderly persons, the offender was identified as a stranger, compared to 66 percent among victims in the general population.

Taken as a whole, the survey findings would indicate that older persons are no more "at risk" than are younger age groups. However, these statistics can in no way minimize the severity of the impact of crime on the elderly—the fear, apprehension, and terror that foster a fortress mentality, keeping many older persons virtual prisoners in their own homes and apartments. Considering the total age distribution, it is indeed paradoxical that while senior citizens are the least likely age group to be victimized, they tend to express the highest level of fear.[9] A recent study conducted at Pennsylvania State University with funding from the Andrus Foundation of the American Association of Retired Persons, revealed that 8 percent of 2,000 elderly citizens surveyed said they actually cross the street or change their direction of travel just to avoid teenagers and restrict their activities to morning or early afternoon hours to stay clear of school-age hoodlums.[10]

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[9] Cook, et al., "Criminal Victimization of the Elderly," Gerontologist, August 1978.

For older people, fear of victimization is probably the most debilitating aspect of crime. This theory is supported by a number of researchers who feel that while the fear of crime among the elderly is real and pervasive, this fear is even more of a problem than actual victimization. In early 1974, the National Council on Aging commissioned Louis Harris & Associates to conduct a comprehensive national survey on the problems of the elderly. Their survey showed that the elderly ranked "fear of crime" as the most serious problem confronting them; 23 percent of those over 65 said that fear of crime is a "very serious problem" for them personally, while poor health elicited a 21 percent response rate. [11] In 1972, the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP) in conjunction with the University of Michigan, conducted a national survey of 4,500 elderly people to determine their needs and concerns. The survey indicated that fear of crime ranked second, following only inadequate food and shelter. In 1973, NRTA/AARP and the University of Southern California undertook a second national survey of 77,000 elderly people. Again crime was ranked as the second item of greatest concern, following food and shelter.[12]

Virtually all surveys on the fear of crime indicate that women have a higher rate of fear than men, that elderly blacks are more afraid of crime than elderly whites and that central city residents have a significantly higher fear of crime in their immediate neighborhoods than do residents of an urban middle class municipality or a suburban retirement community.[13] Robert J. Smith notes, in "Crime Against the Elderly: Implications for Policymakers and Practitioners," that residence in an inner-city setting is one characteristic of older people that causes them to become targets of criminals. The elderly city resident, cognizant of their heightened vulnerability, responds by withdrawing from the fearful environment and remaining behind locked doors. The net result is an obvious reduction in victimization but also a less apparent diminution in the quality of life.

B. VICTIM ASSISTANCE LEGISLATION

The primary legislative thrust in the 96th Congress with respect to crime and the elderly was in the area of victim compensation. This trend has resulted from a growing interest in providing compensation for the innocent victims of crime through programs financed by the Federal and/or State governments.

A recent study by the Center for Criminal Justice and Social Policy at Marquette University examined the needs and problems of citizens in their roles as victims and witnesses, both in relation to the criminal act and citizen participation in the criminal justice system. The study found that victims frequently incur a number of financial costs not reimbursed by insurance. The average nonreimbursed medical costs for 300 victims experiencing physical injury was about $200. The average noninsured costs for property replacement and repairs was $373 as a result of a crime-related incident. While nearly two-thirds of victims are likely to have some insurance protection, one-third, largely in the lower income population, do not.

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[10] Godbey, Geoffrey, Crime Control Digest, Mar. 3, 1980.

[11] Harris, Louis & Associates, Inc., "The Myth and Reality of Aging in America," Washington, D.C., National Council on Aging, 1975, p. 31.

[12] U.S. Congress. House. Select Committee on Aging, Subcommittee on Housing and Consumer Interests, "In Search of Security: A National Perspective on Elderly Crime Victimization," committee print, committee publication No. 95–8, Washington, U.S. Government Printing Office, 1977, p. 38.

[13] Sundeen, Richard A. and James T. Mathieu, "The Fear of Crime and Its Consequences Among Elderly in 3 Urban Communities," the Gerontologist, vol. 16, June 1976, p. 218.

At least 27 States have enacted programs to compensate victims of violent crimes. These programs vary widely in the type and adequacy of benefits provided. In addition, many States are facing serious budgetary problems making it difficult to begin or continue funding victim compensation programs. As a result, the propriety, desirability, and feasibility aspects of such programs have been questioned.

Proponents of governmental compensation for crime victims base their arguments on various rationales. One justification is "society's failure to protect." This theory holds that when an individual has been injured by a criminal act, society has failed to carry out its responsibility to protect that person. A second theory behind crime victim compensation programs is the need to combat the individual citizen's sense of alienation and anger at society and to encourage citizens participation with law enforcement agencies. Finally, proponents argue that if there is Federal interest in helping States prevent crime, to apprehend and imprison criminals, and to house and facilitate the rehabilitation of prisoners, then there also should be Federal interest in helping States to assist the victims of those criminals.

Opponents of Federal assistance to State victim compensation programs argue first that although compensating crime victims can be a legitimate governmental activity, such programs are essentially charitable in nature and not the result of any absolute governmental liability to its citizens. Second, since the Federal Government has no responsibility for the enforcement of a State's criminal laws, it therefore has no responsibility for compensating its victims.

Opponents are also concerned about the long-range costs of such a program. The Judiciary Committee, in reporting the Victims of Crime Act of 1979, estimated that the cost to the Federal Government would be $13 million in fiscal year 1981, $16, $17, and $18 million in fiscal years 1982, 1983, and 1984, respectively. The LEAA issued a report concluding that *total* costs for a national program could range from $144 million to $261 million.[14]

In the 96th Congress, legislation was introduced by Senator Edward M. Kennedy, then chairman of the Senate Judiciary Committee, and by Representative Peter Rodino, chairman of the House Judiciary Committee (S. 190/H.R. 1899). Following markup of H.R. 1899 by the House Subcommittee on Criminal Justice, a clean bill (H.R. 4257) was introduced and favorably reported by the full Judiciary Committee on February 13, 1980 (H. Rept. 96–753).

S. 190 and H.R. 4257, as reported, were substantially similar. Both would have provided grants to qualifying State victim compensation programs in an amount equal to 25 percent of the cost of compensating victims of State offenses and 100 percent of the cost of compensating victims of Federal offenses. Neither would have provided funds for administrative costs and certain other expenses. The maximum award to any one victim or dependents reimbursable under the Senate bill would have been $35,000; the maximum reimbursable award under the House bill was $25,000. The Senate bill would have prevented States from basing eligibility for compensation on the financial means of the claimant; the House version had no such requirement.

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[14] McClure, Barbara, "Crime: Compensation for Victims," Congressional Research Service, Library of Congress Issue Brief No. IB74014.

Major legislation to reform the Federal criminal code (S. 1722) would also have established a program to compensate victims of crime over which Federal jurisdiction exists. The Handgun Crime Control Act of 1979 (S. 1936/H.R. 5823) would have provided for Federal grants to State victim compensation programs for benefits paid for personal injury and death resulting from handgun crimes.

Unfortunately, none of the above-mentioned legislative measures were approved by the 96th Congress.

C. COMMITTEE HEARING ON CRIME AND THE ELDERLY

On Jun[illegible]3, 1980, Senator Pete V. Domenici, then ranking minority member of the Senate Special Committee on Aging, held a hearing in Albuquerque, N. Mex., entitled, "Crime and the Elderly: What Your Community Can Do." The hearing was designed to increase public awareness of the impact of crime on the elderly and to help identify issues for both the reauthorization of the Older Americans Act and the White House Conference on Aging in 1981. Senator Domenici noted that:

> There is no question in my mind that criminal victimization remains a continuing problem for older Americans. When we consider older persons and crime, two key factors come into play—first, the elderly person's heightened vulnerability, and second, the fear that flows from awareness of their condition. There is no section of the Older Americans Act that directs its attention to the subject of crime and the elderly. There is no section that directs its attention to local law enforcement training, community participation, volunteerism by senior citizens in crime prevention and crime information. I urge those of you present today to give some real thought to the feasibility of including a section in the Older Americans Act that focuses on this aspect of the serious problem that you have talked about here today—the suggestion inherent in your discussion—better use of senior citizens in helping other seniors.

Participants included State and local aging professionals, law enforcement officials, and elderly citizens who related their own experiences as victims of crime. In conjunction with and following the hearing, the National Retired Teachers Association/American Association of Retired Persons, the New Mexico Law Enforcement Academy, and the New Mexico State Agency on Aging sponsored a training workshop to promote greater sensitivity to the special needs of older Americans and to explore, in detail, practical, preventive measures for implementation on a statewide or local level. These included:

(1) Providing escort services.
(2) Instituting neighborhood watches/volunteer patrols.
(3) Providing home security improvements.
(4) Designing new public housing to help reduce the incidence of crime; and
(5) Providing special training to police to sensitize them to the needs of older people.

D. DISMANTLING THE LAW ENFORCEMENT ASSISTANCE ADMINISTRATION

The Law Enforcement Assistance Administration (LEAA) was established 12 years ago in an effort to coordinate the Nation's ineffective and disorganized anticrime efforts. Since that time, the LEAA has spent over $7.5 billion in helping State and local officials fight crime—apparently to little avail. In a move reflecting a new wave of fiscal austerity, Congress cut LEAA's budget as part of its attempt to balance the budget. Its main component—grant programs to the States—was wiped out completely, from more than $400 million to zero.

Critics of the LEAA cite its inability to reduce crime, its lack of strong leadership, goals and standards of performance, wasteful spending, and its impetus to a vast new bureaucracy of "criminal justice planners." Two years ago, the Government Accounting Office (GAO) issued a report, noting that LEAA initiated over 100,000 projects that were, at best, wasteful and frequently illegal. A recent Criminal Justice and the Elderly Newsletter (spring 1980), on the other hand, noted that organized elderly in particular have applauded LEAA's support of two major reforms: Programs of community crime prevention and victim assistance programs—neither one of which existed prior to LEAA's creation—and that both programs are making substantial headway in reducing the devastating effects of criminal activities. In addition, even though the LEAA spent more than $7 billion dollars over the course of its 12-year history, this amount is less than 5 percent of all criminal justice spending.

President Nixon made the alarming crime statistics a major issue during a time when America was witnessing increased restlessness and riots in major cities. In fact, one of LEAA's first grants was for riot control equipment for police.

> The agency was never able to escape its image as a wasteful bureaucracy that funded armored cars, night sticks, and tear gas, but did nothing to lower the crime rate.[15]

With the era of agitation apparently in the past, Congress diverted LEAA moneys to programs with rather weak constituencies such as prisons, social programs, and the court system—each focal point clearly failing to deter crime trends. In 1980, when the Office of Management and Budget sent out word to the various departments that budget cuts were necessary, the Department of Justice had only one grant program to turn to—the Law Enforcement Assistance Administration.

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[15] Babcock, Charles R., the Washington Post, "By Bits and Pieces, a Crime-Fighting Program Nears Extinction," Nov. 29, 1980, p. A3.

At present, the agency has nearly $1 billion appropriated to various State and local agencies which will continue to fund certain programs until that money is exhausted. A few programs initiated by the LEAA will remain functional even after LEAA funds are no longer available. These programs include juvenile justice, research, and statistics-gathering programs.

V. CETA—COMPREHENSIVE EMPLOYMENT AND TRAINING ACT

Prior to 1973, a number of categorical federally controlled employment programs were authorized by the Manpower Development and Training Act (MDTA) and the Economic Opportunity Act (EOA). In 1973, with the passage of the Comprehensive Employment and Training Act (CETA), most of these programs were combined into a single-block grant which transferred responsibility for administration to State and local governments.

The 95th Congress reauthorized this legislation as the Comprehensive Employment and Training Act Amendments of 1978 (Public Law 95–524). Section 2 of the act presented a statement of purpose as follows:

> It is the purpose of this act to provide job training and employment opportunities for economically disadvantaged, unemployed, or underemployed persons which will result in an increase in their earned income, and to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency by establishing a flexible, coordinated, and decentralized system of Federal, State and local programs. It is further the purpose of this act to provide for the maximum feasible coordination of plans, programs, and activities under this act with economic development, community development, and related activities such as vocational education, vocational rehabilitation, public assistance, self-employment, training, and social service programs.

Under the administrative provisions of this act, funds flow from the Secretary of Labor to "prime sponsors." A prime sponsor under this act may be a State; a unit of general purpose local government which has a population of 100,000 or more persons; any consortium of units of general purpose local government which include a qualifying unit of general purpose local government; and, any unit of general purpose local government or any consortium of such units, without regard to population, which may have exceptional circumstances as determined by the Secretary of Labor. Prime sponsors receive funds from the Secretary of Labor based on a comprehensive employment and training plan.

A. OLDER WORKERS UNDER CETA

The 1978 amendments, and subsequent regulations to implement these amendments, provided a greater focus on the employment problems of older workers. Title II, the new authority for employment and training programs, provides that the Secretary of Labor shall insure that prime sponsors' plans contain procedures for services to be provided to individuals who are experiencing handicaps in obtaining employment, including those who are 55 years of age and older.

Under the provisions of the Older Workers Initiatives (title II, section 215), the DOL, through prime sponsors, was charged with implementing programs to develop work modes, making it possible for older workers to remain on the job, as well as providing retraining and other support activities.

Title III of the amendments provides broad authority for research and training policies and programs to focus on assuring older workers a more equitable share of employment and training resources to reflect their importance in the labor force. Section 308 of this title provides that the Secretary shall:

—Develop and establish employment and training policies and programs for middle-aged and older workers which will reflect the appropriate consideration of these workers' importance in the labor force and lead to a more equitable share of employment and training resources for middle-aged and older workers.

—Develop and establish programs to facilitate the transition of workers over 55 years of age from one occupation to another within the labor force.

—Conduct research on the relationships between age and employment and insure that the findings of such research are widely disseminated in order to assist employers in both the public and private sectors to better understand and utilize the capabilities of middle-aged and older workers; and

—Develop and establish programs to develop methods designed to assure increased labor force participation by older workers who are able and willing to work, but who have been unable to secure employment or who have been discouraged from seeking employment.

Title VII, Private Sector Opportunities for the Economically Disadvantaged, also requires employment and training opportunities for special groups such as middle-aged or older workers who have been unable to locate suitable employment. The title requires that such opportunities be available by prime sponsors on an equitable basis among segments of the eligible population. It further states that consideration must be given to the relative numbers of eligible persons in each such segment.

Despite the mandates of the CETA legislation, and the assertions by DOL that persons in all working age groups participate in activities under CETA, Congress has continued to express concern that the CETA program is not responsive to the needs of older workers. This concern was underscored in a 1978 study by Schram and Osten.[16] In this assessment of the impact of CETA on the problems of the older worker, the authors examined CETA's history, options and authority arriving at the following conclusions:

—Analysis of CETA data reveals that relatively few older people are served by the program, despite the long-term unemployment suffered by the group. CETA criteria for distributing public jobs emphasize youth through special consideration of veterans, welfare recipients, and manpower trainees; and

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[16] Aging and Work, vol. 1, No. 3, summer 1978.

—The authors find major systemic factors within the CETA program that encourage local prime sponsors to understate the needs of the aging population, concluding that there is a need for substantial changes in CETA if the older worker is to be served effectively.

An examination of participation figures provided by DOL for fiscal years 1979 and 1980 reveal that only a small percentage of prime sponsors provide special programs for older persons and that the percent of workers age 45 or older has declined under some titles. For example, under section 215, DOL reports that 89 prime sponsors provide special programs for approximately 12,000 older persons in 135 projects. The 89 prime sponsors which developed these special programs represent only 19 percent of the 473 fiscal year 1980 prime sponsors. Therefore, the data indicates that a substantial portion of the prime sponsors do not intend to operate programs designed for older workers. However, it should be noted, that some older workers are served by prime sponsors through regular CETA programs. Participation data from these programs are collected on an age "55-plus" category which almost precludes accurate determination of the numbers of older persons employed in regular CETA programs.

In the fiscal year 1982 budget materials published by DOL, the following tables provide socioeconomic characteristics of persons enrolled in CETA programs during fiscal year 1979 and fiscal year 1980. All tables show a decline in the number of participants in the 45 and over age bracket during this time frame.

COMPARISON OF ENROLLEE CHARACTERISTICS BETWEEN 1979 AND 1980 TITLE II–A, B, AND C

Characteristics	1979	1980
Sex:		
Male (percent)	47.1	47.0
Female (percent)	52.9	53.0
Age:		
Under 22	47.9	48.2
22 to 44	44.9	45.3
45 and over	7.2	6.5
Education:		
11 or less	47.5	49.1
12 and over	52.5	50.9
Economically disadvantaged	90.0	98.2

COMPARISON OF ENROLLEE CHARACTERISTICS BETWEEN 1979 AND 1980, TITLE II–D

[In percent]

	1979	1980
Economically disadvantaged	96	96
Female	48	50
21 or younger	23	26
45 or older	14	12
Handicapped	5	6
On public assistance	22	27
Less than high school education	28	33
Black	29	33
American Indian or Alaskan Native	1	2
Hispanic	13	13

COMPARISON OF ENROLLEE CHARACTERISTICS BETWEEN 1979 AND 1980, TITLE VI

[In percent]

	1979	1980
Economically disadvantaged	86	90
Female	43	45
21 or younger	22	24
45 or older	15	14
Handicapped	4	5

B. REAUTHORIZATION OF TITLE VII

Title VII, first drafted as a provision of the 1978 CETA Amendments, established a private sector initiative program (PSIP) designed to encourage prime sponsors to work more closely with local private employers, organized labor, community-based organizations and educational agencies to experiment with approaches which would place disadvantaged persons in private sector employment.

On March 12, 1980, a bill to amend and extend title VII of CETA (H.R. 6796) was introduced by Congressman Hawkins. The House Committee on Education and Labor, to which the bill was referred, favorably reported the bill out of committee on May 15.

The House Committee on Education and Labor, in their report (H. Rept. 96–985) accompanying H.R. 6796; addressed problems that older workers encounter with CETA and charged DOL as follows:

> The committee reminds the Department of Labor of its obligations to insure that the CETA program better respond to the needs of older workers, whether it be in title VII or elsewhere.

The report also indicated both DOL and the prime sponsors regarding programs for older workers with the following statement:

> Despite the mandates of the 1978 CETA Amendments which called on prime sponsors to establish programs specifically for older workers, as of March 1980, only 89 of 473 prime sponsors had, in fact, established such programs. This represents less than 20 percent. The CETA program cannot continue to ignore the older worker. We instruct the prime sponsors to include older workers in any agreements they make with private industry under the terms of title VII.

The House passed H.R. 6796 on September 15, the Senate on December 8, and the measure was signed into law (Public Law 96–583) on December 23, 1980. With the passage of this legislation, Congress once again had affirmed support for employment and training programs for older workers.

Fiscal year 1980 appropriation provided $8.1 billion for CETA programs. DOL estimates that approximately $260.6 million, or approximately 3.2 percent, was spent on employment and training for workers age 55 and over as follows:

Title:	*Million*
II–B and C	$59.8
II–D	91.6
VI	99.2
III, section 303	2.1
III, migrants	5.2
III, Native Americans	2.8

97TH CONGRESS } SENATE { REPT. 97-62
1st Session } { Part 2

PART 2—APPENDIXES
DEVELOPMENTS IN AGING: 1980

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 353, MARCH 5, 1980

Resolution Authorizing a Study of the Problems
of the Aged and Aging

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MAY 13 (legislative day, APRIL 27), 1981.—Ordered to be printed

U.S. GOVERNMENT PRINTING OFFICE
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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., May 13, 1981.

Hon. GEORGE BUSH,
President of the Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 353, agreed to March 5, 1980, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1980, Part 2.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1980 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. During the second session of the 96th Congress, Senator Lawton Chiles served as chairman of the Special Committee on Aging. The preparation and writing of this report was largely accomplished during 1980 under Senator Chiles' leadership. I deeply appreciate that extensive contribution and his continuing cooperation in completing this important publication.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

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PART 2—APPENDIXES

DEVELOPMENTS IN AGING: 1980

MAY 13 (legislative day APRIL 27), 1981—Ordered to be printed

Mr. HEINZ, from the Special Committee on Aging, submitted the following

REPORT

APPENDIXES

Appendix 1

ANNUAL REPORT OF THE FEDERAL COUNCIL ON THE AGING

JANUARY 29, 1981.

DEAR MR. CHAIRMAN: On behalf of the Federal Council on the Aging, I am pleased to submit a preliminary copy of the Council's 1980 annual report of the Federal Council on the Aging.

The report summarizes various positions taken by the Council on a number of legislative and other issues concerning the well-being of the elderly. We hope the Council's views will be considered as the 97th Congress convenes.

We appreciate the continuing support and interest of the Special Committee on Aging and look forward to another year of cooperative efforts with committee members and staff toward our mutual goal of service to older Americans.

Sincerely,

MSGR. CHARLES J. FAHEY, *Chairman*.

Enclosure.

COUNCIL MEMBERSHIP

The Council is composed of 15 members appointed by the President with the advice and consent of the Senate so as to be representative of rural and urban older Americans, national organizations with an interest in aging, business, labor, and the general public.[1] Seven members of the Council are themselves older persons. The President designates the Chairman from among members appointed to the Council.

MEMBERS

Chairman, Rev. Msgr. Charles J. Fahey, director, All-University Gerontology Center, Fordham University, New York, N.Y.

Vice Chairman, James T. Sykes, director, public service, the Wisconsin Cheeseman, Madison, Wis.

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[1] Legislation requires five members to be older persons.

Cyril H. Carpenter, president, Minnesota Farmers Union; and member, Governor's Council on Aging, Bloomington, Minn.

Jacob Clayman, president, National Council of Senior Citizens; president of the Industrial Union Department of AFL/CIO; and former member, Federal Advisory Council on Employment Security, Bethesda, Md.

Nelson H. Cruikshank,[2] former Counselor to the President on Aging; former president, National Council of Senior Citizens; former director, Department of Social Security, AFL/CIO, Washington, D.C.

Fannie B. Dorsey, director, Division for Aging Services, DHR, Bureau of Social Services, Frankfort, Ky.; chairperson (since 1974) State Institute of Aging with Kentucky Department of Human Resources, Owensboro, Ky.

Aaron E. Henry, Phar. D., pharmacist, chairman, board of directors, National Caucus on the Black Aged; and member, Mississippi State Legislature, Clarksdale, Miss.

Shimeji Kanazawa, member, Commission's Policy Advisory Board for Elderly Affairs; and vice chairman, University of Hawaii Gerontology Center Project's Steering Committee, Honolulu, Hawaii.

Mary A. Marshall, member, House of Delegates, Commonwealth of Virginia, Arlington, Va.

John B. Martin, legislative consultant, National Retired Teachers Association and American Association of Retired Persons, former Commissioner on Aging, Chevy Chase, Md.

Rev. Walter L. Moffett, director, Nez Perce Tribal Housing Authority; and former area vice president, National Congress of American Indians, Kamiah, Idaho.

Mary C. Mulvey, Ed. D., vice president, National Council of Senior Citizens; and president, National Senior Citizens Education and Research Center, Providence, R.I.

Bernice L. Neugarten, Ph. D., professor, Northwestern University; and Deputy Commissioner, 1981 White House Conference on Aging; past president, Gerontological Society, Chicago, Ill.

Jean J. Perdue, M.D., medical director, Office of Health Services; and member, Commission on the Ministry to the Aging of the Episcopal Diocese of S.E. Florida, Dade County, Fla.

Fernando M. Torres-Gil, Ph. D., professor, University of Southern California; former Special Assistant to the Secretary, HHS; former White House Fellow, Los Angeles, Calif.

Wesley C. Uhlman, attorney at law, former mayor, Seattle; and former chairman; Task Force on Aging, U.S. Conference of Mayors, Seattle, Wash.

1980 MEETING DATES

A. Council

The Council met four times during the year, as required by the Older Americans Act. All meetings were in Washington, D.C., on March 17, 18; June 16, 17; August 25, 26; and December 1, 2, 3.

B. Committees and Task Forces

Committee meetings were held as follows: Long-term care, January 18, February 28, April 15, June 24, all in Washington, D.C.; mandated study group, January 5, February 3, 4, May 19, July 28, November 17, December 17, all in Washington, D.C.; senior services, March 3, July 18, in Washington, D.C.; social security task force, March 3, Washington, D.C.; special aging populations, January 23–25, Louisville, Ky., August 5, New York, N.Y.

All Council, committee, and task force meetings were announced in the Federal Register and notices of the meetings sent to representatives of national organizations, to staff of various Federal agencies and to congressional members and committees with a special interest and responsibility in the field. Representatives of these groups and the general public usually attend Council meetings.

Documents pertinent to official actions are maintained in the Office of the Council and are available to the general public.

---

[2] Former Chairman.

COUNCIL MEETINGS SCHEDULED FOR 1981

March 9, 10, 1981
June 29, 30, 1981
August 31, 1981
September 1, 1981

(Note: All 1981 meetings are tentatively scheduled to be held in Washington, D.C.)

I. INTRODUCTION

LEGISLATIVE HISTORY AND MANDATE OF THE FCA

The Federal Council on the Aging (FCA) is the functional successor to the earlier and smaller Advisory Committee on Older Americans created in the 1965 Older Americans Act. The Council was created at a time, 1973, when there was concern within the Congress as to the adequacy of the then-existing Federal system arrangements for looking after the interests of older persons and as to the breadth of vision likely to be reflected in such oversight and assessment.

Having decided to upgrade (supplant) the existing advisory committee, the Congress found "model" legislative language readily at hand—in the legislative charter of the U.S. Commission on Civil Rights. That legislative language was simply adapted to define the powers of the FCA, but excluding the subpena power.

What the FCA was constituted to do was stated in section 205 of the 1973 Amendments to the Older Americans Act of 1965 and the subsequent 78 amendments as follows:

The Council shall—

(1) Advise and assist the President on matters relating to the special needs of older Americans.

(2) Assist the Commissioner in making the appraisal of the Nation's existing and future personal needs in the field of aging.

(3) Review and evaluate, on a continuing basis, Federal policies regarding the aging and programs and other activities affecting the aging conducted or assisted by all Federal departments and agencies for the purpose of appraising their value and their impact on the lives of older Americans.

(4) Serve as a spokesman on behalf of older Americans by making recommendations to the President, to the Secretary, the Commissioner, and to the Congress with respect to Federal policies regarding the aging and federally conducted or assisted programs and other activities relating to or affecting them.

(5) Inform the public about the problems and needs of the aging, in consultation with the National Information and Resource Clearing House for the Aging, by collecting and disseminating information, conducting or commissioning studies and publishing the results thereof, and by issuing publications and reports; and

(6) Provide public forums for discussing and publicizing the problems and needs of the aging and obtaining information relating thereto by conducting public hearings, and by conducting or sponsoring conferences, workshops, and other such meetings.

Having thus provided a legislative mandate for the Council that was broad enough to allow misinterpretation of congressional intent, members of the conference committee went on record as expecting a strongly proactive Council. They said of the FCA that:

—It "is intended to be the principal spokesman in the executive branch for America's older citizens and to provide the visibility, identification, and advocacy that have so long been lacking in the relations between the elderly and their Government."

—It "would provide valuable support for the President's efforts to mobilize the various agencies of the executive branch to meet the needs of older Americans."

—It "would serve to provide both the executive and legislative branches of our Government with a steady input of information regarding the problems of senior citizens."

The conference report tried to sum it all up by saying "It is the intention of conferees that this body function as more than a passive advisory body, and that it work to actively promote the interests of older Americans throughout the whole range of Federal policies and programs affecting them."

The Council is required by law to prepare an annual report which is submitted to the President by March 31 of the ensuing year. In addition to the legal requirement, the annual report probably represents the Council's most effective public relations tool. Each year approximately 7,000 copies are distributed to Members of the Congress, governmental agencies, aging organizations, private agencies, institutions of higher education, and to individual citizens throughout the United States.

Funds appropriated for the Council are a line item in the overall appropriation of the Department of Health and Human Services. These funds are used to underwrite meetings of the Council; to support the activities of a small professional and administrative staff in Washington, D.C.; to conduct special project activities; and to "contract out" for special research activities.

The Council has worked closely with both the administration and the Congress, and has shared with each the results of its public hearings, research, and special analyses of issues and policies affecting older Americans.

The President transmits each report to the Congress together with his further comments and recommendations.

The legislative authority for the Council will expire in 1981.

(Note: See appendix B for a description of the Council's functional operations and procedures.)

II. Recommendations of the Federal Council on the Aging

OVERVIEW

The seventh annual report of the Council consists of a number of recommendations to the administration, the Congress, and Federal agencies. The Council's primary focus of concern was initiating and completing the congressionally mandated study as authorized by Public Law 95-478, the Comprehensive Older Americans Act Amendments of 1978, section 205(g). Therefore, the number of recommendations made by the Council in 1980 pertaining to the immediate and future well-being of the elderly is a reflection of its commitment to the Congress mandate to study programs under the Older Americans Act.

A. NATIONAL POLICY FOR OLDER WORKERS

1. Age Discrimination in Employment

(1-a) The Equal Employment Opportunity Commission (EEOC) should change the current set of regulations on ADEA which permit employers to not credit years of service beyond age 65 in calculating a worker's final retirement benefit.

Background and Discussion

Whatever the reason which allowed employers not to credit years of service beyond age 65 for ultimate pension benefit levels, it is, of itself, wrong. A worker beyond age 65 who is able and meeting job performance requirements is entitled to the terms, benefits, and privileges of employment. Continued pension credit is among such benefits and privileges. Furthermore, employers surveyed in the studies mentioned above felt that the impact of extending credits for years beyond age 65 would be minimal. They expect relatively few workers to stay beyond that age, and those who do stay for relatively short periods of time. Extending pension credits for those workers, therefore, is no real problem since the cost factor associated with this action is minimal. In addition, many employers expect labor unions to bargain collectively in favor of extending pension credits beyond age 65 which becomes another reason to support the issue.

The principles and values associated with this study which were presented at previous Council meetings state that disincentives with a tendancy to inhibit the free choice of older and capable workers to remain employed or take on new jobs should be removed. The lack of crediting years of service beyond age 65 for purposes of final pension benefits constitutes such a disincentive. By making the recommendations, the Council supports the EEOC in revisions for the current regulations.

(1-b) Congress should remove the provision in ADEA (Public Law 92-256, 92 Stat. 189, 1978) which permits employers to refuse to hire or to terminate a worker if age, of itself, can be shown to be a bona fide occupational qualification (BFOQ) essential for the performance of a special job.

Background and Discussion

When exceptions to a regulatory law appear to become the rule, then serious reconsideration as to the purpose and validity of such an exception is in order. Under the ADEA, as that exception now stands age hiring limits and mandatory retirement rules can be set for police and firefighters in relatively arbitrary fashion. Refusal to hire after age 30 is common while forced retirement at age 45 or 50 is not uncommon. Furthermore, many older and some younger incumbents in these positions are challenging the age restrictions in the courts as they grow more aware of their rights.

The difficulty involved with BFOQ exception as it now exists is that it allows confusion between age, ability, and job performance. No one wants an incompetent police officer wielding a gun, or a marginal pilot flying an airplane. Functional criteria should be used in assessing both ability and job performance. When aging and health restrictions interfere in hiring and termination policies because of an exception in a law which intended to protect the rights of older workers. Then the time for change has come.

It is noteworthy that the removal of the exception would in no way saddle employers with substandard workers. Any such worker, regardless of age, race, or sex can be removed, or refused a job, when good cause is shown. Removing the BFOQ exception, however, would place the burden of proof squarely on the employers with substandard workers. Any such worker, regardless of age, race, perceived notion of older worker ability or limitation.

(1–c) The Department of Labor pursuant to the mandates of the ADEA, should develop and implement, in collaboration with other appropriate Federal agencies, a specific research, training, and information dissemination program directed at employers in order to highlight the skills and experience that middle-aged and older workers possess.

Background and Discussion

The statement of purpose of the ADEA includes positive directives as well as prohibitions. Thus, the act is intended "* * * to promote employment of older persons based on their ability rather than age and * * * to help employers and workers find ways of meeting problems arising from the impact of age on employment." The act further states that: "The Secretary of Labor shall undertake studies and provide information to labor unions, management, and the general public concerning the needs and abilities of older workers and their potentials for continued employment and contribution to the economy." The legislation continues to enumerate a number of steps which, regrettably, have never been carried out with any serious efforts. It is time to reexamine this aspect of the legislation and see how it can be implemented. Furthermore, clarifications are in order as to which agency, the Department of Labor and the Equal Employment Opportunity Commission, has responsibility for carrying out research and educational functions.

The ADEA does specify that the DOL should take positive steps to develop and disseminate information on older workers. However, this mandate should be viewed more broadly. The Administration on Aging is one agency which has an interest in developing and promoting research in areas that help older persons remain independent. Another agency, the Department of Commerce, through its Economic Development Administration, should be interested in the employment-related effects of its grants and how these affect job opportunities for older workers, especially in rural areas. The Social Security Administration, with a view toward conserving its resources, should also be interested in ways to promote productive, ongoing labor force activity for older workers beyond the conventional retirement age.

This effort should not be limited to Government alone. Private foundations should be encouraged to support research and develop information which can positively influence the utilization patterns of older workers. The recommendation, then, looks to Government to take a leading, stimulating role towards the ongoing effort of developing a positive base for older worker policy.

(1–d) The mandatory retirement limit, set at age 70 in the 1978 amendments to the ADEA, should be abolished.

Background and Discussion

In recommending the abolition of mandatory retirement the FCA remains consistent with the belief, values, and principles embodied in this study, namely that individuals be assessed and evaluated for job performance on ability rather than age. This, taken together with expected minimal effects of such action on other younger labor force groups supports the recommendation. The Department of Labor is currently conducting a study on the effects of changed retirement age and likely effects of raising or abolishing the upper limit. It would be a more cautious position to wait the outcome of this and other studies. However, in its leadership role on behalf of older people, the FCA adopts the positive recommendation now.

2. Employment Programs

(2–a) The Department of Labor should direct regional administrators and local prime sponsors to comply with the specific CETA planning requirements, outlined under titles I and II of the act, directing that a special labor force analysis be completed on older workers and other targeted groups. The results of the analysis are to be used in formulating special service programs for these groups. Specifically, the Department of Labor should carry out appropriate procedures, including regional and local oversight hearings, if necessary, to assure compliance with the Age Discrimination Act (ADA) of 1975, as amended—especially as this statute applies to all CETA training programs.

Background and Discussion

This is the first that older workers have merited such specific planning and service requirements in CETA legislation. Each prime sponsor is not required to assess the older worker's need within his jurisdiction and respond to those needs in an equitable and positive manner. As statistics attached to the report show older persons tend to participate in CETA programs in declining percentage rates directly related to advancing age. The mainline training programs are almost entirely youth focused. However, questions may be raised if one group appears to receive more CETA program resources than another. In summary, the older worker should expect fairer treatment under CETA than in the past. In fact, if a prime sponsor neglects one particular group within the planning mandate, the individual may encounter sanctions.

There are many individuals who claim that CETA is a youth program especially focused on the needs of unemployed, underemployed, and disadvantaged young members of minorities. Sharing resources with older workers would only dilute the program. There exists also the assumption that training and employment investments should be made in the younger, as opposed to the older group, while the older ones will be, at best, leaving. The investment and payoff, then, can be viewed as tilting toward the elderly.

Regardless of such underlying considerations, congressional intent in the 1978 CETA amendments requires that planning and program services be allocated to older workers on the local level. Without expecting any great change of heart or miracles, participation rates of older persons in CETA programs should manifest an upturn over the coming years.

The Age Discrimination Act of 1975 prohibits discrimination on the basis of age in all major programs funded by the U.S. Government. The act admits to certain exceptions especially where age is specified as a statutory criteria for participation. Thus, the act does not apply to social security programs where age criteria for eligibility and participation are specified. Nor would the act apply to day-care programs for children where age criteria are also specified. In addition, the act does not apply to employment since Congress reasoned that the ADEA covered this area. But the act does apply to training programs funded by the Federal Government which can lead to employment.

Enforcement of ADEA is largely an oversight function of any Federal agency covered by the act with DHHS summing a larger coordinating and conciliating role. As applied to CETA, then, the Labor Department would be required to apply by reason of equity and ADEA requirements what is its mandate by the planning requirements of title I. The ADEA provides another mechanism to assure that older workers receive a fair share of the Nation's development of employment.

Both the law and the planning requirements noted above will offer group concerned with older workers more leverage to assure they receive a fair share. On the other hand, it is felt on a policy level that the Nation's disadvantaged youth needs the greater share of CETA resources, in this case; new programs and new appropriations must be developed for older workers. Extended employment opportunity for the able and willing older worker is no longer condescension, it is a protected civil right. Coupled along with a new approach to develop the productive older worker resource, new policies and new programs funded on a basis of need and equity are in order. In short, it is discriminatory policy to assert that billions of dollars will be allocated for one age group and only millions for another.

(2-b) Federal regulations which exclude workers from participating in apprenticeship programs funded by the U.S. Government solely on the basis of age should be abolished.

Background and Discussion

Ever since the inception of the Manpower Development and Training Act (MDTA) of 1962, apprenticeship programs funded by the U.S. Government and conducted by labor unions, have had age ceilings for acceptable applicants. In some cases, individuals over age 25 were denied access to these programs, not to speak of being over 30, 40, or 50. The assumption behind these age exclusions was, and still is, that training investment in older workers will not pay off, or that it will take too long for the older worker to gain the journeyman level of skil to really contribute to the trade or to the economy. Whatever the original policy behind each exclusion, the situation is different now. There are many women in the middle years who want and need to enter the labor force in a trade-skill capacity. They need the opportunity for apprenticeship training. Men and women in their 50's can look forward to at least 20 years of labor force activity if they are willing and able. Skill conversions through apprenticeship training is by no means out of the question. Changing demographics, changing interest on the part of workers, increasing challenges to age restrictions in the world or work and the raising of mandatory retirement age all suggest that restrictions on apprenticeship programs on the basis of age are unwarranted and should be abolished.

Recent discussion among members of the Equal Employment Opportunity Commission indicate Commissioners are concerned with the age-related restrictions on apprenticeship programs. Congressional staff interview in the key informant stage of the study also have expressed concerns over the issue. Some are considering introducing corrective legislation of the Federal agencies empowered to change the regulations do not take action. Whatever the type of action that occurs over the near future, the FCA should go on record in support of abolishing age restrictions.

(2-c) The Department of Labor should allocate at least $10 million in fiscal year 1981 to implement the middle-aged and older worker program described in title III, section 308, of the 1978 CETA amendments.

Background and Discussion

Section 308 of CETA provides for a wide variety of employment-related research and demonstration programs affecting the employment of middle aged and older workers. The legislation supports innovative approaches for retraining and utilization of these workers. Special research on the development of functional criteria for assessing skills and abilities of older workers, as opposed to formal tests, is encouraged. Second career training and the use of alternative work patterns, job redesigning, flexible scheduling for work, etc., are also suggested demonstration approaches. At present, no appropriation has been made to support any of the above activities. The whole title III program is discretionary as to fundings and it is up to the Secretary of Labor to make the allocations.

The Council has already made its views known in support of appropriations for section 308. The Chairman has met and discussed the issue with the Secretary of Labor. $10 million would appear to be a reasonable beginning amount for this new older worker program, especially in consideration of how poorly older workers have fared in the past.

In the 1950's the Bureau of Employment Security (BES) of the Department of Labor conducted extensive research of older workers in a number of major labor markets to assess such factors as numbers, sex of older persons seeking jobs compared to younger applicants, reported obstacles faced by older job seekers, employer attitudes on older workers including ability, productivity, motivation, their hiring practices, etc. The result of the studies indicated that older workers, defined by the Bureau as individuals over the age of 45, were encountered special problems when seeking employment and needed special assistance.

The BES then established a national older worker program which developed and implemented counseling and referral programs for older applicants, trained BES staff to carry out training and employer relation activities to assist older workers and established, in many States, a cadre of older worker specialists to implement the above functions.

For historical reasons, such as the changing of priorities of employment programs and the initiation of "Great Society" programs to help minorities, the older worker effort diminished. Some States have maintained services for older workers, but a concentrated program focus on the part of the DOL for this group no longer exists.

It would be inappropriate to suggest that the same older worker program be revived. First, with the inception of the decentralized CETA program, the changes that have occurred in the Employment Service and the availability in the communities of a host of agencies that are concerned with the elderly, a new design for the program is needed along with a sharing of program resources and collaboration among interested groups. Greater access to older persons and the assessment of their labor force interests and their needs is available through the area agencies on aging (AAA). However, AAA's staff needs training in detailing with and counseling the elderly. A number of older pilot programs financed from CETA 308 might prove to be the best first step. Given a careful development and evaluation period, there is no reason why effective older worker programs cannot be put in place over the coming years.

(2–d) The senior community service employment program under title V or of the Older Americans Act should be expanded on the basis of:

—An assessment of the proportion of workers in need of the program over the next 5 years; and

—An assessment of the impact and effectiveness of the program in terms of benefits to participants, services to agencies and people served, and the overall benefit to the economy and the Government.

Background and Discussion

The title V program has grown in numbers of participants and funding levels over the years. The program is currently (fiscal year 1981) funded at $265 million and provides work for over 52,000 older workers who meet specified poverty criteria.

Administratively, title V is managed by the U.S. Department of Labor which in turn, utilizes a number of national subcontracts, mainly agencies with a standing record of providing services to the Nation's elderly. These groups have been expanded recently to include State units on aging (SUA) and organizations with special concerns for the Nation's minority elderly.

Title V has been and remains very successful and popular. It puts older workers in a position of providing a variety of needed services and self-dependence gained by achieving earnings through employment. But a number of issues need to be considered:

—What is the true universe of need for programs in terms of older participants and the new kinds of work which they can, and are willing to perform?

—Given the double-digit inflation, are the poverty criteria for selection into the program realistic. Are participation criteria too restrictive?

—Should the program take on a greater job training emphasis and involve private sector and mainline Government agency employer in greater job development efforts?

—Can the basic program model which views participants as "aide" be changed so that seniors in every level of management, can be trained to become a major provider services to their own peers?

These many issues will be raised by the Council in its mandated study. In looking over the prospects and promises of the program over the coming decade, it might be helpful if the DOL would join in a major evaluational and development effort. The last assessment of the program was undertaken almost 10 years ago by a consultant group under contract with the DOL. The evaluation was sound, thorough, and positive. In fact, the model can serve as a point of departure for the FCA mandate study pertaining to the title V program and a supplemental effort made by the DOL which manages the program.

3. New Employment Opportunities

(3–a) The Department of Labor should develop an affirmative action program for middle-aged and older workers to assure that these individuals gain access to jobs made available through Federal contracts to major employers in the United States.

Background and Discussion

Since the passage of the Civil Rights Act of 1964, and especially title VII, which protects the employment-related civil rights of minorities, the Government has made efforts to enforce a series of affirmative action programs which are intended to guarantee a fair share of jobs and upward mobility on jobs to minorities covered by that legislation. Furthermore, in cases litigated under the act, the Federal courts have ordered, or otherwise arranged, for procedures whereby employers take direct action to restore any imbalances in their work forces that might have resulted from past discrimination.

Women have benefited from these arrangements especially through "consent decrees" whereby the Federal courts have withheld punitive actions against employers in lieu of specified steps to rectify promotion rates, salary and wage scales, etc., that might have been influenced by discriminatory actions on the basis of sex.

There is no reason why older workers should not benefit from an affirmative action approach. The principle at stake here is one which is fundamental to this policy study. What is a civil right for one subgroup of the U.S. labor force and population is a civil right for all. There can be no tradeoff on demographic characteristics of the population when it comes to the right to work by individuals who are willing and able.

In supporting this recommendation, the Council is supporting a principle and program of fairness. No one is asking for a special break for older workers or a special opportunity. We are asking for equity. Older workers are the only subgroup in the population who, at present, are not included in affirmative action programs.

(3–b) Congress should establish a special unemployment insurance and job retraining program for middle-aged and older workers to enable them to remain in or reenter the labor force when economic pressures force them to withdraw from the labor force involuntarily.

Background and Discussion

One of the most distressing labor force statistics which applies to workers over 40 is the continued pattern of duration of unemployment. The longer an over-40 worker is unemployed, and actively seeking work, the longer he/she tends to remain so. The duration of unemployment expands in proportion to the increased age of the older job seeker. This pattern has held for well over a 10-year period of reporting on such trends. But special studies involving plant shutdowns, mergers or other events which affect local areas also underscore the same phenomenon. Once out of a job, the older and not-so-old worker will look for reemployment and benefit from unemployment insurance for an interim period. After that period expires, the older worker is likely to leave the labor force completely and resort to some form of welfare dependency.

It would seem that if current retraining and relocation efforts, such as those provided through trade adjustment programs, were modified, the older worker would benefit and could remain in the labor force for longer periods. What seems unproductive is to neglect the older worker, or just sustain his unemployment insurance for a more extended period, and not build on that investment. Again, the Council is facing the underlying values of this recommendation. Invest in the older worker in terms of income maintenance and job retraining can pay off for the individual and for the economy. There is a healthy mix of humanitarian and economic motives involved in the focused development of the unemployment insurance resource and any added training efforts. Older workers can retain their status in the labor force including the power to earn income and benefit from other work-associated values. The economy benefits since the worker remains a taxpayer. Retirement systems benefit since the worker defers drawing upon these income resources.

Pilot demonstration efforts on this approach plus careful evaluation of costs and savings, both individual and economic, may be the best initial step for such a program.

(3–c) Congress should establish a retirement alternative employment program which would:

—Provide workers with incentives to defer retirement; and

—Provide employers with incentives to develop retention options for older employees.

Background and Discussion

Since the inception of the 1978 amendments to the ADEA which raised mandatory retirement to age 70, a number of employers have developed creative approaches toward retaining able older workers and hiring others. The general pattern has been to develop various lines of part-time jobs along with flexible work schedules. Employers have been pleased with the arrangement because they note that older workers are productive. Older workers are pleased with the arrangement also since they are able to continue earning and remain active. But there are problems. First, the benefit arrangement is not clear in all cases. Part-time work does not necessarily mean reception of partial benefit. Sometimes workers take reduced pay and still have to wait until retirement to receive pension benefits. Second, not all employers appear interested in such an approach. Those organizations with a long-standing value on older employees, and many which either raised or abolished mandatory retirement before the law set the age to 70, normally, are the ones which appear flexible and willing to develop differential work opportunity for individuals who would normally retire. What is needed, then is a retirement alternative program which would both educate and encourage employers in the public as well as in the private sectors to develop retention programs and hiring opportunities for older workers.

We already have the means to accomplish the programmatic aspects of such an effort. Title V, of the Older Americans Act, the senior community service employment program, provides an ample precedent in the design of part-time work for older workers. Translating that approach to a broader scale, especially in the private sector, would require careful demonstration. Providing incentives to employers to participate in and to develop retention programs would require adjustments in the system already used to encourage them to hire and to retain minority youth who come out of CETA training programs. Tax incentives, stipends, or salary wage maintenance for a period of time, maintenance of training and other job-related supports, are among the strategies that have worked. Designing a total package to facilitate older worker retention and the hiring is feasible.

(3–d) The Department of Commerce, Agriculture, and Labor should collaborate with the Small Business Administration and the Administration on Aging to develop and assess economic impact programs which will identify entrepreneurial, job, and other self-employment opportunities for middle-aged and older workers.

Background and Discussion

The Department of Commerce, through its Economic Development Administration, offers grants to a variety of economic development districts in order to achieve growth and stimulate developmental activity in those areas. Eligible organizations can build or expand facilities through the grants program which has the effect of creating jobs. It is important that this Federal resource, be shared equitably in the job creation aspect by all age groups. But it may be more important that the above Federal agencies collaborate in targeting training, employment, and developmental activities in a focused way to help older workers gain job opportunities in all areas including entrepreneurship and other self-employment activities.

The collaborative economic, manpower development is by no means new. It has been tried with various degrees of success in a number of settings. What is called for is a careful review, evaluation and planning approach which will build-on positive past experiences. It may well be that any effort that will succeed must be broad based, involving the maximum resources in terms of funding and agencies along with cross-generational sharing of the employment opportunities that arise from such economic development programs. It is unlikely that any economic development effort could, or should, benefit only one age group. All should benefit in an equitable manner—based on labor and job market analysis. Younger and adult workers may need full-time jobs. Older workers may prefer part-time work. Such analyses are complex, not to speak of the difficulties in program planning and coordinating. If areas eligible for economic development grants from Federal agencies are to utilize them effectively to support and stimulate local jobs, new efforts must be made to assure that all groups benefit fairly.

4. *Retirement Policies*

National retirement policy, as manifested through the social security system and regulatory laws affecting pensions, should be reassessed with a view toward encouraging continued, varied, and nontraditional employment opportunities for middle-aged and older workers.

Background and Discussion

This is a general, overall recommendation which takes into account previous recommendations. It is realized that making employment options a part of retirement policy may at first appear contradictory. It is, if we continue to review the life cycle in a segmented fashion that moves, inexorable from youth education to adulthood and work and to retirement in old age. But demographic factors, increasing longevity and improved health for older persons along with cloudy economic forecasts for this decade simply challenge static thinking about retirement policy. Key informants from the President's Commission on Pension Policy noted, that retirement and employment issues for older persons are inextricably related. The Commission has consistently investigated alternatives to retirement along with its mission to rationalize the Nation's pension system. That focus is instructive to the Council and all others concerned with the economic well-being of older persons and their status as self-sufficient.

B. CONTINUING EDUCATION FOR OLDER ADULTS

Recommendation

In recognition that education is a basic right for all persons of all age groups, that it is continuous and hence one of the ways of enabling older people to have full and meaningful lives, and a means of helping them develop their potential as a resource for the betterment of society, the Federal Council on the Aging and the National Advisory Council on Extension and Continuing Education, a public statutory body established by Congress to aid in public policy development at the Federal level on matters relating to postsecondary education and learning opportunities for adults in the United States, have recommended to Secretary Hufstedler (Department of Education) that a Federal strategy for increased educational opportunities be developed and directed toward:

(B.1) The appointment of a coordinator for aging in the Department of Education to develop coordination with the Administration on Aging and other relevant Federal departments and agencies.

(B.2) The immediate establishment of an aging unit in the Department to initiate supportive educational services for older people as a necessary first step in any expansion of educational opportunities for older persons on a national scale.

(B.3) Coordination of education and aging networks at the State, area and local levels, including State departments of education, State offices on aging, area agencies on aging, public agencies which administer social security programs, voluntary organizations, postsecondary institutions (including technical institutes, community and junior colleges), local school districts, business and industry, and unions.

Background and Discussion

Education for older Americans is too often dismissed as a legitimate concern of the Federal Government, as is education for adults generally. There have been few national policies or stated purposes, and little adequate resources devoted explicitly to encourage education among the elderly. If sentiment does not change this condition, the reality of numbers may. A dramatic shift in demography is transforming us into a nation of older people.

In the past 10 years, enrollments by older and nontraditional students in postsecondary education have increased four times as fast as enrollments by traditional college-going youths between the ages of 18 and 22. In fact, education and training for adults, who tend to go to college on a part-time basis, is the most rapidly expanding segment of all postsecondary education.

This fact ought to be of special concern to the Department of Education. In the very near future, older learners are expected to outnumber and replace younger students as the "typical" undergraduates on our Nation's campuses. Once established, this pattern appears assured for the next two decades. In 1960, 4.3 million Americans were born. In 1978, only 3.3 million Americans were born. In short, the graduating class of the year 2000 has already been born and will, in all probability, be taught then by the same individuals teaching now.

There are three principles guiding Federal education policies. These are the principles of equity of access to education, equal educational opportunities, and the right of every American to expect and to receive quality instruction. These principles have been put into practice successfully for some Americans. There remains a serious question whether or not these principles have been universally extended to all learners, especially adults, and particularly older adults. With older Americans demonstrating a strong interest and need in continuing their education, it is important that the Federal Government have the legislation, the programs, and the commitment to encourage this interest, not discourage it by muted interest or arbitrary rules and regulations that discriminate against older Americans who wish to continue to learn.

C. HOUSING FOR THE ELDERLY

Recommendation

That the Federal Council on the Aging, while realizing the importance of Federal budgetary efforts to combat inflation, recommend to the administration and Congress—

(1) That they urge an increase in the funding level for Section 202: Housing for the Elderly and Handicapped, to enable the construction of 30,000 units. The present budget for 1981 proposes loan authority for $830 million to support an estimated 18,000 units. Such housing is desperately needed by our elderly population and is a most cost effective way of preventing premature or inappropriate institutionalization.

(2) That the congregate housing and services program receive a fiscal year 1981 appropriation in the amount of $25 million since the $10 million appropriated in fiscal year 1980 will only provide services for 60 housing projects.

(3) That sufficient funding be provided for assisting 600,000 units of public housing (section 8) including 400,000 units of HUD section 8 and 200,000 units of Farmers Home Administration and HUD section 235.

Background and Discussion

For a period of time the Council has had an unending commitment to a Federal policy that would improve housing conditions for a significant portion of the Nation's elderly. The essential problem faced by the elderly in housing is income. If older people had enough income they would probably buy adequate housing.

Historically, the Department of Housing and Urban Development (HUD) has concentrated its energies on the construction of housing units, but presently is coming to the realization of the important social role to be played in solving the problem of the poor; that provision of a house, by itself, is not enough to solve these problems.

While the funding levels required for the above-mentioned housing units may seem high, appropriations to complete these units will provide shelter for only a small portion of the elderly individuals and households in greatest need of these services.

III. COUNCIL ACTIVITIES

During 1980, the Council worked in a number of areas of special concern as well as inviting attention to emerging issues of importance to the elderly of the present and future. Specifically, the largest portion of the Council's agenda was the congressionally mandated study (to be described elsewhere in this report).

The 1980 Council activities were centered around the following committees and/or task forces:

A. LONG-TERM CARE

Activities of the Federal Council on the Aging in long-term care date back to 1975. At that time, the Council initiated development of its first report on recommendations for a national policy on services to the frail elderly. This publication, entitled "Public Policy and the Frail Elderly," was made available in 1979. The Council then turned its attention to delivery system and in 1979 disseminated a paper identifying the key issues in long-term care. The Council's Long-Term Care Committee convened a work group composed of 18 representatives from seven Federal departments with policymaking and program responsibilities impacting on long-term care. This group provided expert advice to the committee in the development of its key issues paper.

This work group also provided expertise on the most pressing areas of inquiry. One result of the work sessions is the chartbook to be published by the Council in early 1981. The chartbook presents information and issues on the need for long-term care. The committee convened a data task force of persons knowledgeable in various aspects of long-term care to develop the specific topic areas for the chartbook. The task force included members from national associations and consulting firms as well as from Federal agencies.

The purpose of the chartbook is to present information and issues in determining current and future need for long-term care. It brings together four mainstreams of information on the need for long-term care by America's elderly; data on demographics, health status, use of health services and informal supports. A fifth section discusses the impact of Federal policies on the delivery of long-term care. The information represents a mosaic of diverse pieces which combine to provide a better understanding of the complex issues concerning the need for long-term care.

In many of the charts, data on the past and projections for the future are presented along with current information. This perspective in three time frames is important to understanding the need for long-term care because it sheds light on where we were yesterday, shows how we got where we are today, and forecasts where we are going. The data point to interrelationships that have important impact on the need for long-term care—ties between age and disability, education and income, minority status and longevity, living alone and being female.

The chartbook was prepared with many users in mind—delegates to the 1981 White House Conference on Aging, policymakers, program planners, legislators, and all others concerned with the aging of the American people.

Chairperson: Charles J. Fahey. Members: Mary A. Marshall, Jean J. Perdue, M.D.

B. MANDATED STUDY WORK GROUP

The FCA mandated study work group had the major responsibility for identifying and framing the issues relevant to the congressionally mandated study. The work group worked with and advised the consultants who authored FCA conceptual papers on age as a criterion for focusing public programs, targeting under the Older Americans Act and policy development and advocacy. Additionally the work group helped to formulate and define the problem focus and advise on methodology with respect to the contracted studies undertaken by the Council in 1980. In short, the work group provided the overall leadership for the Council toward achieving the objectives of the congressionally mandated study.

Chairman: Wes C. Uhlman. Members: Mary C. Mulvey, Bernice L. Neugarten, Charles J. Fahey, James T. Sykes, Fernando Torres-Gil, Bill Holland (FCA study director).

C. SENIOR SERVICES

The primary focus of the Senior Services Committee in 1980 was its study on the employment of older workers (see discussion of this topic in the section on recommendations). Second, the committee participated in the development of an interagency agreement to provide small business enterprise and employment opportunities for the older worker. (Note: Some of the principals involved in this effort other than the Council were the Administration on Aging, the Small Business Administration, the Farmers Home Administration, the Economic Development Agency, the the American Bar Association, and the U.S. League of Savings Associations.) Finally, the committee proposed, as a beginning toward developing a work plan in the housing area, a resolution which was adopted by the full Council on increased funding for section 202 and the congregate housing and services programs (see full text of resolution in section on recommendations).

Chairperson: James T. Sykes. Members: Aaron Henry, Mary C. Mulvey.

D. SOCIAL SECURITY TASK FORCE

The social security task force studied specific issues involving gender-based inadequacy and inequity in the social security system. Topics under consideration included divorce, disability, dependency, poverty among widows, and dual entitlement. The Council received the task force's efforts as work in progress; therefore, no specific recommendations for action were made.

Chairperson: Mary Marshall. Members: Aaron Henry, Mary Mulvey, James T. Sykes.

E. SPECIAL AGING POPULATIONS COMMITTEE (SAPC)

The Special Aging Populations Committee followed up on recommendations emanating from the committee's report on "Policy Issues Concerning the Minority Elderly." The followup was accomplished by sending letters to the various Federal agencies having direct or indirect responsibility for aging programs.

With respect to its commitment to the needs and problems of both urban and rural elderly residents the committee engaged in the following activities:

1. On the Rural Elderly

(a) In January, the committee met with State and local officials, service providers as well as grass roots in Louisville, Ky. While in Kentucky, the SAPC members visited some rural and urban senior centers and shared with the center's participants their differing needs.

(b) Also in January, the committee was represented in a title VI hearing in Anchorage, Alaska. The major concerns pointed to the difficulties in obtaining services in the isolated, culturally unique, and poverty-stricken Indian villages.

(c) In April, the committee was represented and testified at a hearing on the "Plight of the Rural Elderly," sponsored by the Senate Special Committee on Aging, in Las Vegas, N. Mex.

(d) In April, the committee was also represented and participated at various workshops on the rural elderly during the National Council on the Aging Conference, in Washington, D.C.

(e) In May, the committee participated in the annual conference of the National Caucus/Center on the Black Aged in Philadelphia.

2. On the Urban Elderly

The committee worked closely with the National Urban League in planning a workshop on "Inner City Elderly Living Facilities." The workshop was held in conjunction with the National Urban League Annual Conference in New York on August 5, 1980.

Prior to the workshop, committee members visited with staff from the New York Office on Aging, toured areas with heavy congregation of boarding homes, and single room occupancies.

Committee members explored with residents, SRO operators, providers of services and researchers, the major problems and alternatives.

Chairperson: Fernando Torres-Gil. Members: Fannie Dorsey, Cyril Carpenter, Walter C. Moffett.

IV. 1981 WORK PLAN

During 1981, the Council will continue working in a number of areas which have occupied much of its time as well as devoting attention to emerging issues of importance to the elderly of the present and future. The Council's agenda will also be affected by actions concerning the elderly by a new administration and changes in the composition of the legislative branch of government.

To follow is an indepth discussion of some of the major Council concerns in 1981 and a listing of others including a time schedule depicting the percentage of time to be given per topic.

EMPLOYMENT

In 1980 the FCA approved a series of recommendations regarding the public sector's responses to the needs of older workers. These recommendations were developed in the FCA report entitled, "Toward a National Policy on Older Workers." In 1981 the FCA will pursue the second phase of its study on older workers. This task will continue throughout the calendar year, and will include: (1) Monitoring public debate on older workers (congressional hearings, President's Commission on Pension Policy, etc.); (2) presentation of testimony representing the FCA's position on the older workers issues; and (3) participation in a joint initiative with public and private organizations that will test various mechanisms for including older workers in our economic system both as entrepreneurs and as employees.

It is expected that the outcome of this phase of the study will allow policymakers to form a more focused opinion on the issue as well as generating new questions for public debate.

The FCA will spend 5 to 10 percent of its time pursuing these activities.

TARGETING OF RESOURCES FOR THOSE IN GREATEST NEED

It is clear that government has assumed the responsibility of ameliorating inequality in our society. This responsibility is reflected in a variety of policies and programs. Yet, a large number of these direct themselves specifically to income inequality. Under these programs, assets and income are used to judge the eligibility of a person or household for participation in a particular program. The present method of "means testing" is a weak surrogate for "needs testing," i.e., identifying economic and noneconomic needs. It is becoming increasingly clear that, in society where public dollars for social programs are not unlimited, more efficient and equitable methods for identifying the real "in need" groups must be devised and implemented.

Various new approaches to the general problems surrounding the targeting of resources for those in greatest need have surfaced recently and are the source of intense debate. It is clear that the debate will continue into the future.

A large number of older Americans are served by "needs tested" programs. The FCA will, in 1981, formulate a conceptually sound and programmatically acceptable policy position on the issues surrounding targeting after considering the size and direction of the tradeoffs in equity, target efficiency, and program costs resulting from variations in approach.

The FCA will employ its role as convenor by bringing together those knowledgeable in this area.

Approximately 10 percent of the FCA's time will be spent in this area.

SOCIAL SECURITY

The current financial outlook for the OASDHA program indicates several problems. The OASI program is running out of funds as automatic benefit increases exceed the growth in revenues. It is clear that additional financing will be needed throughout the 1980's. The possible forms that the revised financing scheme could take are of extreme interest to the FCA because social security is the most important national program affecting the well-being and economic security of both the present elderly and those who will retire in the future.

In the past the FCA has urged that short-term financing problems be corrected. This was especially true with the decoupling issue. In 1981, the FCA will study, review all proposed mechanisms for returning OASDHA to a sound financial footing. Congressional debate will be monitored and testimony will be given as the FCA deems appropriate. The FCA will spend 5 to 10 percent of its time pursuing these activities.

MANDATED STUDY

The study is to be presented to Congress in March or early April 1981. Prior to that time the study will be the major FCA activity. This involves review and comment on findings and a decisionmaking process on options and recommendations. Until completed, the study will involve 70 to 80 percent of FCA time. Following completion and throughout the remainder of 1981, followup activities on the study will take 10 to 15 percent of FCA time. These include meetings with congressional committees, national aging organizations and presentations at major meetings and conferences. Decisions will be made for followup facets of the study that are timely and priority areas for followup be established and pursued.

LEGISLATION

Reauthorization of Older Americans Act—here the FCA has the opportunity to develop a short-range position and a long-range position (possibly based on findings from mandated study)—the short-range position, paper on the position and testimony will take 5 to 10 percent of FCA time. The long-range position and paper another 5 to 10 percent of FCA time.

Other legislative concerns—5 to 10 percent of FCA time. These include new programing, energy, income, health care, and positions on existing programs. The FCA will decide the most appropriate methods to use to be engaged in the legislative process.

WHITE HOUSE CONFERENCE ON AGING

This is a major FCA activity through 1982. A major block of FCA time (30 percent) will go into direct support by members and staff of the conference. After the conference of major portion of FCA time (20 percent) will go into followup activities aimed at maximizing the results of the conference process. The FCA will prioritize and categorize the Council agenda in light of conference outcomes.

UPDATING FCA STUDIES

Many recommendations in FCA studies are relevant and have not been implemented. A review will be done of studies and a plan on implementation or further promulgation of recommendations will be presented to the FCA. The studies include: Formula study, benefits study, tax study, minority elderly study, assets study, public policy and the frail elderly. Five percent of FCA time will go into this activity.

A Study of Living Arrangements of Older Persons

This long-range policy study (2 to 3 years) will build on findings from prior FCA work—frail elderly, long-term care, minority elderly, benefits study. The study will attempt to develop policy that will lead to the most appropriate range of community based living arrangements in a system for all older persons that is based on need and acceptability. Ten percent of FCA time for this activity.

A Study on the Future Role of the Family, Informal Supports, Other Mediating Structures and the Elderly

This intermediate range policy study is complementary to the living arrangements study. Questions to be addressed include:

(1). What do present policies encourage on the role of the family and the elderly?

(2). Is dependency on family a desired social goal?

This activity will take 10 percent of FCA time.

A Study of the Feasibility of Developing Reports on Measures of the Status of the Well-Being of Older Persons

This long-range policy study would determine the ability to measure the status of older persons in society and would include health status, economic status, and other social indicators of well-being. This activity will take 10 percent of FCA time.

V. THE FCA CONGRESSIONALLY MANDATED STUDY

The 1978 amendments to the Older Americans Act require that the Federal Council on the Aging undertake a thorough evaluation and study of the programs conducted under the act. The law requires the study to include at least three parts:

(1) An examination of the fundamental purposes of such programs, and the effectiveness of such programs in attaining such purposes.

(2) An analysis of the means to identify accurately the elderly population in greatest need of such programs.

(3) An analysis of numbers and incidence of low-income and minority participants in such programs.

Separate funds were not appropriated for this purpose. To achieve a useful, focused result, the FCA obtained help in the Department of Health and Human Services from the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and from the Administration on Aging (AoA).

The expected level of effort is approximately 8 to 10 person years. The Administration on Aging authorized a transfer of $500,000 of 1 percent evaluation funds to the FCA for these purposes.

KEY DATES AND EVENTS TOWARD ACHIEVING THE OBJECTIVES OF THE FCA CONGRESSIONALLY MANDATED STUDY

The following represents a chronology of the important dates and events germane to framing the issues and achieving the objectives of the mandated study.

January 5, 1980

The FCA Mandated Study Group met on Janaury 5, 1980, to consider the implications of the AoA exploratory evaluation for: (1) Its formulation of conclusions regarding the fundametal purposes and effectiveness of programs conducted under the Older Americans Act, and (2) for additional special analyses and short-term evaluations of the efficiency, effectiveness, and responsiveness of programs conducted under the Act.

The work group decided to:

(1) Incorporate the results of the AoA exploratory evaluation and of all others relevant ongoing AoA program evaluation studies into its report to Congress (the latter will take the form of evaluation summaries based on readily available date).

(2) As a part of the short-term evaluation of the AoA program based on evaluation studies in progress, Commission policy papers on six to eight topics related to the values and parameters underlying programs conducted under the Older Americans Act. Finally, after further deliberations, the study group decided on hiring consultants to develop the following policy and/or conceptual papers:

Policy paper I: Age as a Criterion for Focusing Public Policy.

Policy paper II: Policies and Program Strategies for Reaching. Those in Greatest Need.

Policy paper III: Achieving Effectiveness in Policy Development and Advocacy in Aging at the National Level.

Policy paper IV: AoA Program Strategies for Community Service System Development.

The purpose of this aspect of the study was to obtain expert advice regarding potential program improvements of the programs conducted under the act. This advice will be an input to the Council to help it formulate its policy recommendations to the Congress and to the Department.

(3) Undertake a limited series of new special analyses and evaluation studies designed to:

—Identify the best means of identifying those in greatest need (a congressionally mandated analysis).

—Determine what is known about current low-income and minority group participation levels in programs conducted under the Older Americans Act (a congressionally mandated analysis).

—Assess the effectiveness of the Title V: Community Service Employment Program; and

—Answer a series of specific questions about AoA's effectiveness in fostering community service system development and to define exemplary community service systems. (Note: this study will provide information on evaluation design options for assessing community progress in developing systems of services for the elderly and for assessing the progress of State units on aging and area agencies on aging in fostering the development of such systems.)

May 18, 1980

Between January 5 and May 18, request for proposals (RFP's) were developed for the special analysis studies including the identification of potential contractors. Also, the requirements for the policy option papers were developed and the identification and hiring of writers (consultants) for the papers were completed.

The FCA study group met on May 18 with the paper writers and reviewed the outline of each paper. Also, a status report on the overall progress of efforts toward achieving the objectives of the mandated study was presented. Additionally, special assignments were given to each member of the mandated study group and FCA staff to monitor each paper and contracted study.

May 21, 1980

An overview of the FCA congressionally mandated study was made to the Hill staff by the mandated study director and FCA staff.

June 16, 17, 1980

The major issues of the mandated study were reviewed with the full Council.

July 28, 1980

The Council met informally with the leadership council of aging organizations for the purpose of seeking their input on the issues being addressed and the process being used by the Council in responding to the mandated study.

August 24, 1980

The FCA mandated study group met with a paper writer and explored in depth the issues on "Age as a Criterion for Focusing Public Programs."

August 25, 26, 1980

The full meeting of the Council on August 25 and 26 featured an intensive and provocative discussion of the mandated study with the full Council focusing on the issues and concerns of the policy papers and studies to be undertaken. The overall discussion on the mandated study was led by Wes C. Uhlman, chairman of the mandated study group.

November 16, 17, 1980

A comprehensive review and analysis of options and positions were presented to the mandated study group by the study director and FCA staff.

December 1, 1980

A briefing on the progress of the policy options papers, and contracted studies was made before the full Council. Also, preliminary findings, conclusions, and recommendations were discussed reflecting both the papers and contracted studies.

December 17, 1980

The mandated study group and FCA staff met with members on the leadership council of national organizations to receive their comments relative to the FCA findings and recommendations on:

(1) Title III, grants for State and community programs on aging—services development and system building under the Older Americans Act.

(2) Targeting under the Older Americans Act.

(3) Policy advocacy at national level.

(4) Title VI, research and training programs.

The target date for the delivery of the report to the Congress is March 31, 1981. (Note: See appendix E for a listing of the critical issues pertinent to the mandated study.)

APPENDIXES

Appendix A

1981 WHITE HOUSE CONFERENCE ON AGING

Throughout 1980, the Council made the 1981 White House Conference on Aging one of its primary agenda items. Of primary concern was the role of the Council relative to the White House Conference on Aging. A consensus among the White House Conference on Aging Advisory Committee members seem to be that the Council assume a major role in the Conference process and, most importantly, in the followup period of implementation of the recommendations which will come from the December 1981 meeting.

At its December 1–3 meeting, the Federal Council on the Aging took formal action on this matter and passed a resolution which outlined FCA plans to undertake major responsibility for monitoring and cooperating with others to implement recommendations to emerge from the 1981 White House Conference on Aging.

The Council believes that this role is in keeping with the legislative authority and function of the Council, namely: "(The Council shall) review and evaluate, on a continuing basis, Federal policies regarding the aging and programs and other activities affecting the aging conducted or assisted by all Federal departments and agencies for the purpose of appraising their value and their impact on the lives of older Americans."

The seven members of the Council (Charles J. Fahey, Cyril Carpenter, Jacob Clayman, Aaron Henry, John Martin, Bernice Neugarten, and James Sykes) who also share dual status of membership on the White House Conference on Aging advisory body will serve as the Council committee that would determine and coordinate the role of the Council, its members and staff in relation to the 1981 White House Conference on Aging.

Appendix B

FCA OPERATIONS AND PROCEDURES

The Council is required by law to conduct a minimum of four meetings per year. Therefore, it is the policy of the Council to conduct a minimum of four regular meetings per year, and to provide sufficient time during each meeting to allow for reasonable review, discussion, and resolution of Council business.

The purpose of the Council meeting is to provide a forum for orderly discussion among the membership and for deliberation and determination of issues related to the Council's legislated mandate.

All meetings of the Council must be open to the public and reported in the Federal Register 30 days prior to the meeting. It is the staff's responsibility for submitting all legal notices and for advising other interested agencies and individuals as appropriate.

Conduct of all Council meetings requires a quorum of the membership to be present. A quorum is the simple majority of current appointees for a regular Council meeting. Occasionally Council members may have to leave the meeting room briefly; the quorum is officially maintained for the purpose of conducting the day's business.

Council meetings normally consist of 1½ or 2 full, consecutive day sessions. The opening session includes approval of previous meeting minutes. The closing session includes discussion of tentative items to be placed on the next meeting agenda.

Items to be listed on the meeting agenda can be suggested by Council members and/or staff. These items are submitted to the special assistant to the chairman who has the responsibility for developing the agenda in consultation with Council chairman and executive committee. It is necessary and legally required, that major items on the agenda be determined and the public notified of issues to be considered.

At least 1 week to 10 days prior to each meeting, the staff mails the agenda to the entire Council membership and a selected mailing list of government and nongovernmental agencies and officials. Also, specific background materials are mailed to acquaint Council members with specific agenda items, when appropriate. The staff compiles all other meeting documents, papers, and related materials into a portfolio or folder for each Council member.

For purposes of accurate recording of the proceedings of a Council meeting, a professional stenorecorder is hired to record verbatim all formal proceedings. This record is made in compliance with the Federal Advisory Committee Act and is available to the public upon request at the Council staff office. A synopsis of major discussion and decisions of a meeting is distributed to the members in the form of minutes prepared by Council staff, principally by the executive assistant.

Federal legislation has established broad and complex responsibilities for the Council. To this end, the Council recognizes the intent of the legislation to provide a means for including a variety of representation from throughout the populace in the policymaking process of the Federal Government. In order to best utilize the specialized knowledge and expertise of all of its members, the policy of the Council is to apportion specific activities among its members, reserving ultimate review and approval authority for the vote of the entire membership.

Furthermore, the Council has established a policy of conducting apportioned activities through the operation of task forces which correspond to distinctly identifiable responsibilities.

The Council recognizes that although the legislated, broad responsibilities of its mandate remain constant, the means for accomplishing specific goals, and the recognition of current, relevant issues, may fluctuate. Therefore, task forces are established on a temporary, as-needed basis to conduct a specific program of work as a means of accomplishing an identified goal(s) and/or objective(s).

Once a committee or task force is established, a member of the professional staff will be assigned to be responsible for coordinating staff activities and to be the principal contact between the committee or task force chairman and other Council members.

Committee or task force members are expected to attend all the meetings of that committee or task force and to review all documents and other materials pertinent to the work of the task force. In addition, staff is responsible for:

(a) Keeping abreast of documents, issues, and legislation related to the work of the committee or task force and advising members as appropriate.

(b) Making committee and task force meeting arrangements including preparing the meeting agenda, securing speakers and facilities, writing and disseminating appropriate notices, and preparing materials.

(c) Writing progress reports and keeping committee members informed. (Note: Copies of all correspondence, progress reports, and related documents are routinely provided by staff to the Council chairman.)

Appendix C

TIME CHART FOR WORK PLAN (STAFF MEMBERS)

Topic	January	February	March	April	May	June	July	August	September	October	November	December
Mandated Study	80% FCA time			20% FCA time						25% FCA time		
White House Conference on Aging	20% FCA time											
Employment	0			5-10% FCA time								
Targeting	0			Part of 20% Mandated Study Follow-up								
Social Security	(as needed reactive)			5-10% (proactive) FCA time								
Legislation	(as needed reactive)			5-10% (proactive) FCA time								
Update FCA Studies	0				5% FCA time							
Living Arrangements	0				10% FCA time							
Family Informal Supports, Other Mediating Structures	0								10% FCA time			
Well Being of Older Persons	0								10% FCA time			

Appendix D

FCA MANDATED STUDY ISSUES

POLICY TOPIC I: AGE AS A BASIS FOR SOCIAL POLICY

Issue: What role should age play as a criterion for focusing public policy and social programs?

Discussion Questions

(1) How meaningful is age as an eligibility condition of program participation?

(2) How meaningful is age as a basis for targeting services? How meaningful is age as a proxy for need?

(3) Should the government promote age-integrated or age-segregated service systems?

(4) What are the major policy implications of an aging society for the design of programs funded under the Older Americans Act?

(5) What role should factors other than age play in rationing public benefits and services for the aged population?

Conclusions

(1) "From its passage (then) and embodied in the Declaration of Objectives, Older Americans Act services were to be available to any person aged 60 and over, under the presumption that if old, one had *need* for such services." (Kutza)

(2) "One—at every age—has need for services that enhance one's social well-being. Society has an obligation to provide generally for those needs—e.g., parks, theaters, safety, life-enhancing opportunities. (Sykes) How a society decides collectively to finance such services is a separate question."

(3) Chronological age *as such* is an arbitrary rationing device.

(4) Chronological age is a weak indicator or proxy for need.

(5) Resolution of this issue requires a careful delineation of the uses that chronological age and age classifications might have in relation to public policies and programs. (E.g., chronological age might be used as an eligibility foundation to ration the benefits of a program; it might serve as a general presumption or proxy for need for some service; or it might simply serve as the condition defining the client group for outreach, program development, or other similar purposes.) The reasonableness of age classifications has to be judged on the basis of their intended use in serving legitimate State interests. Because uses and interests vary widely with the particular program or government function to be served, such judgments require careful consideration of the specific context in which the classification is to be used.

(6) Because of these complexities, general conclusions have limited usefulness apart from a specific context defined in terms of the use to be made of age, the type of program or government function, and the State interest to be served.

POLICY TOPIC II: RESOLVING THE APPARENT DILEMMA OF WHO SHOULD BE SERVED

Issue: Who should be served by Government programs funded under the Older Americans Act?

Discussion Questions

(1) Is the dual focus justified or should it be changed?

(2) What justifies a dual focus? (a) The nature of the problems facing older persons; (b) the diversity of programs authorized and funded.

(3) Is the answer different if the financing question is separated from the issues of *what* programs and *what* services are needed? E.g., *personal* social services versus social action programs; *or*

(4) Is the answer different if the focus is on different types of Government responsibilities or roles? E.g., law enforcement versus publicly financing social services; or access services versus other social services?

(5) What are the implications of the need and service data?

(6) Does raising this issue really constitute another way of asking what the Government's priorities ought to be? E.g., economic security first, jobs, housing, and health care next?

Conclusions

(1) The legislative intent of the act is clear in generic terms. Specifically, the act authorizes activities and programs intended to serve all older Americans

while targeting social and nutrition services toward those with special social or economic needs; title III also requires preference for those in greatest need.

(2) The universe of unmet need for services and programs is reasonably well-understood in general terms; it is not, however, defined with precision and specificity for each social service or even for nutrition services. Needs, wants and preferences are not easily distinguished. The resolution of this question is actually accomplished in the reauthorization and appropriations process which is not always very rational. There is a fairly clear consensus about the general need for some services (e.g., legal services and certain access services) but not others.

(3) There is a need for a reasoned basis to establish long-range policy goals and priorities for program development under the Older Americans Act. At the present time, the active disagreement about priorities regarding such broad policy areas as economic security, jobs, housing, health care, and social services for older persons appears to hamper effective program development, especially under title III of the Older Americans Act.

POLICY TOPIC III: THE ELDERLY AS A NATIONAL RESOURCE

Issue: How can the Congress and the Departments of Labor and Human Services establish effective programs to achieve the best use of the elderly population as a national resource?

Discussion Questions

(1) (a) Are some of those responsibilities on an age-specific basis? (b) Should some of those responsibilities be met on an age-specific basis? (c) Should efforts directed at employment or employability of the elderly be targeted to those who are identifiable as "traditionally disadvantaged"?

(2) Should Federal efforts directed at employment of the elderly be means-tested?

(3) (a) Are there Federal laws which prohibit or act as disincentives to gainful employment? (b) Are those regulations which prohibit or act as disincentives to gainful employment? (c) Are there barriers to entrancing employability which the Federal Government could reduce or remove?

(4) (a) Are present efforts adequate? (b) What approaches are most effective? (c) What new programs might be needed? (d) How are positive results measured? (e) How are negative results measured?

Conclusions

(1) The Federal Government has a responsibility to enhance the potential for usefulness of each of its citizens to assure their autonomy and control over as broad a range of individual options as possible for as long as possible.

(2) The independence guaranteed by self-support is an important contribution to an individual's array of options and personal autonomy.

(3) Employment and employability are both conditions affected directly by Federal policies, processes, and programs.

(4) There is a Federal responsibility to affect positively, and not to affect negatively, the employability and opportunities for the employment of the elderly population which otherwise competes at a disadvantage against other citizens in the labor market.

POLICY TOPIC IV: FEDERAL POLICY TO ACHIEVE EFFECTIVE TARGETING

Issue: What policies should the Federal Government employ to promote effective targeting of services to those in greatest economic or social need?

Discussion Questions

(1) How can existing targeting strategies be improved?

(2) Should targeting goals be established on a national level or on the State/area/local level?

(3) Which strategies should be used in identifying target populations?

(4) Which approach to targeting is preferable: (a) A technical assistance and monitoring strategy, or (b) an enforcement strategy?

(5) What are the possible advantages of targeting resources to meet the needs of specific populations? More and better services to those most critically in need?

More flexibility to focus on the unique problems of the elderly subpopulations at individual State levels? E.g., large subpopulations of minority elderly in poverty? More flexibility to alter service delivery strategy to meet changing needs of various subpopulations, e.g., older women?

(6) What are the possible disadvantages of targeting resources to serve the needs of specific populations? Increase the size of subpopulations of elderly needing more costly services, e.g., nursing homes, hospitals, etc.? Carried to an extreme, would targeting be counter productive? Place a stigma on the image on programs for older Americans?

(7) Which incentives might work to improve targeting? One based on using broad dissemination regarding what is known about best practices? One based on discouraging program utilization by those elderly with other resources?

POLICY TOPIC V: FEDERAL POLICY FOR SERVICES DEVELOPMENT AND SYSTEMS-BUILDING UNDER TITLE III OF THE OLDER AMERICANS ACT

Issue: For national policy purposes, what policies and principles should guide priority-setting for services development and system-building under the Older Americans Act?

Discussion Questions

(1) What type of systems should be promoted? What kind of service system should AAA's try to build at the local level?

(2) How should priorities for services be established—by statute, by regulation, by Federal administrative decision, by State and local decision?

(3) How can reasonable expectations be defined for State government in its role in implementing Older Americans Act programs?

(4) Under the Older Americans Act, what substantive policy should be used by the Federal Government in promoting local service systems? Specifically, should AoA focus on all community services, primarily on health and social services, or primarily on the problem of long-term care? What policy should guide such priority-setting?

(5) What functions should AAA's perform to foster the development of desirable service systems?

(6) What relationships should AAA's have to HSA's, to title XX agencies and other similar State and local community planning organizations?

(7) Should the Federal Government promote consolidated intergovernmental management structures for the planning and delivery of health and human services to the elderly?

(8) Can AAA's provide services directly and also serve effectively as information gatherers, and planning agencies stimulating program development and assuring the quality control of services and service delivery?

Conclusions

(1) At the national level, the accountability for services development and system-building at the State and local levels has been defined largely in process, activity, and input terms. AoA's management's long-range developmental objective is to establish local aging service systems that insure access to care, treatment, and other social services, adequate community based social and nutrition services, adequate in-home services and adequate services in care-providing facilities. AoA's strategies for achieving such program development have been focused selectively on certain services such as transportation services, legal services, and the long-term care ombudsman program.

(2) Expectations regarding the development of comprehensive, coordinated local service systems need clarification, especially in the light of known resources constraints.

(3) There is a need to document successful services development and system-building as a basis for future program development and program evaluation. (The Federal Council has undertaken a short-term study to determine the feasibility and cost of such program development and future full-scale evaluation.)

(4) Past evaluations show that the Administration on Aging, and the State and area agencies on aging have made some measurable progress in achieving appropriate developmental objectives under title III of the act. On the basis of readily available information from such past evaluations and a selected number of other relevant studies; the Council reached *no* general conclusions regarding the effectiveness of the "network" at the State and substate levels as vehicles for

services development and system-building. There are studies—such as the 1976 Steinberg study, the Westat study and (perhaps) the Estes-Newcomer study that document some success—as well as room for improvement. (Note: The GAO will be in a position to illuminate the performance of State units on aging and the area agencies on aging after the results of their national survey are ready in the spring 1981.)

(5) There are fundamental policy issues regarding services development and system-building under the Older Americans Act. Specifically, it is unresolved whether the Government should develop a fully comprehensive categorical system of services for the elderly or should provide services to older people through a more generic human services delivery system. Relative priorities among social services are debated periodically in the authorization and appropriations process. Usually the debate is highly contentious and not very rational. It would be useful to have a more clearly defined general strategy for such program development.

POLICY TOPIC VI: PUBLIC LEADERSHIP IN POLICY FORMATION—ADVOCACY UNDER THE OLDER AMERICANS ACT

Issue: Are redirections and improvements needed at the national level to clarify and upgrade AoA's and the FCA's advocacy role in the agency policy formation process?

Questions We Have Addressed

(1) Are expectations realistic and sufficiently well-defined? If not, how can expectations be clarified and made realistic?

Options to consider

(A) *Define expectations regarding the advocacy function in terms of* (1) the quality of brokering and negotiating for change; (2) the degree of apparent influence of advocates on decisionmakers (executive and legislative); (3) the specific results achieved in legislative, budgetary and administrative processes; or (4) specific types of major reform of Federal policy in aging (e.g., expect successful leadership in achieving a coherent national manpower policy in aging, or a coherent Federal policy for long-term care services for the elderly).

(B) *Develop measures around* (a) coherence of national level policy in selected policy areas; (b) extent of rights, benefits, and entitlements protected; and (c) extent of new rights, benefits, and entitlements created for the elderly.

(2) Are radical changes needed? Should the policy-oriented advocacy function be separated from AoA's other basic functions.

(A) *Maintain the advocacy and policy development framework established under the 1978 Older Americans Act Amendments.*—Involved here is an assessment of the advocacy record, potential and limitations of the Administration on Aging, the Federal Council on Aging, the National Institute on Aging, the Center for Studies of the Mental Health of the Aging, and the White House Conference mechanism (as currently organized, charged, and interrelated) in light of the criteria developed in part II.

(B) *Maintain the existing Older Americans Act advocacy framework, but substantially reorganize and strengthen it by:* Elevating AoA within HEW; increasing AoA's policy review staff and capacity; increasing staff and policy development capacity of the Federal Council on Aging; clarifying roles and expectations among AoA, OHDS, the Federal Council, and NIA in order to maximize positive and complementary interaction vis-a-vis advocacy.

(C) *Consolidate the broader advocacy functions of the Administration on Aging into the responsibilities of an enlarged Federal Council.*

(D) *Create a new Federal aging agency with Older Americans Act advocacy and program responsibilities under a Presidentially appointed commission.*

(E) *Eliminate the Federal Council on Aging and create a citizen advisory group to a more advocacy-oriented Administration on Aging.*

(3) Are process changes needed?

(A) Are improvements needed in policy agenda setting, information gathering and synthesis, collaboration to solve problems and improve policies?

(B) How does the AoA see the Council's relationship to older Americans as a potential FCA/AoA client group or constituency?

(C) Is the Council's role in the long-term care policy area a possible model for a Council relationship to the AoA, the Department, the Congress, and the clientele?

(D) What role should State and substate level advisory councils play in relation to the Federal Council's role?

Conclusions

(1) At present, expectations are poorly defined and the program design is implausible.

(2) A more coherent national policy in aging is needed to resolve the apparent dilemmas caused by the generic and broad mandates of the Older Americans Act.

(3) Current expectations regarding AoA and FCA's roles in national aging policy formation are not realistic—given their structure, other basic functions, staffing, and other resources, and the wide distribution of responsibilities throughout the executive branch, the Department and the Congress.

(4) The advocacy role needs to be defined to permit: (a) Agreement on its appropriate role, (2) appropriate expectations, (c) agreement on objectives against which to measure its effectiveness, and (4) clear directions on which to base management decisions regarding actions and resources.

(5) Methods are needed to clarify the roles of AoA, OHDS, NIA, OASPE, OS, and the FCA and to establish a process that will consistently produce topics for data collection, data synthesis, policy discussion, and followup action.

(6) More systematic and visible use should be made of the State and area agencies, and the voluntary nonprofit sector as vehicles for policy agenda-setting, information gathering and synthesis and other actions.

(7) AoA still lacks the organizational capacity to manage actively for leadership in aging policy formation in the Department and in the executive branch. A design change may be needed.

(8) The results of effective advocacy are best measured by the growth of strength and status and diminution of the needs and vulnerabilities of the advocate's client or constituency.

POLICY TOPIC VII: KNOWLEDGE BASE FOR POLICY AND PRACTICES IN AGING—AOA'S RESEARCH AND TRAINING PROGRAMS

Issue: Should AoA's research and training programs be more visibly integrated into AoA's other major program elements to achieve more support of its mission?

Discussion Questions

(1) What direction has AoA given the overall R.D. & E. program? (a) Has it supported advocacy satisfactorily? Has it supported services development and system-building satisfactorily? (c) Has it supported the research in social gerontology and the related aging policy sciences satisfactorily? (d) Has it supported the evaluation function satisfactorily? (e) Has it accomplished any results? (f) Has its impact been felt?

(2) What initiatives can AoA management take to shape a research program as an integral part of AoA's activities supporting its key mission elements? (a) What are the constraints on centralized priority setting? (b) What are the limitations of the resource levels? (c) What are the in-house skills needed to operate a research program? (d) Can a process be developed to operate a multipurpose program economically? (e) Which audiences are most difficult to satisfy with research information? (f) Can AoA identify the purposes of its mission which are supported by meeting the needs of a given audience?

(3) Is the evaluation function organized as a program at the Federal level? (a) Has it identified objectives of the respective subprograms? (b) Has it differentiated the constituencies and clientele of the respective subprograms? (c) Has it developed means of identifying and measuring impacts of the subprograms? (1) At the State and/or local level? (2) At the project level? (d) Can it institutionalize feedback of its findings?

(4) Have there been useful results generated by AoA research efforts? (a) In development of skills? (b) In development of delivery techniques? (c) In development of administrative or enforcement process? (d) In development of evaluative measures?

(5) Has constructive learning been generated by AoA research efforts? (a) Have information gaps been filled? (b) Have useful institutions, individuals, or programs been supported? (c) Have useful questions been generated? (d) Have data been refined or made more reliable? (e) Have casual questions been validated and/or answered? (f) Has policy changed direction or degree of control as a result of research? (g) Have State, local, or service delivery personnel indicated use of AoA products? (h) Have the elderly reflected interest in a satisfaction with any AoA research products?

Conclusions

(1) Titles II and IV in combination, authorize a multipurpose program intended to support all elements of the AoA mission.

(2) The title IV program is intended to build a knowledge base for long- and short-range policy formation in aging. Research, demonstration, and evaluation activities have a major role to play in:

—Developing new knowledge for tomorrow's services for future generations of aged.

—Advocacy in the public policy formation process; and

—Services development and system-building.

(3) There is evidence that AoA's research has made a contribution to the field of social gerontology, to constructive policy formation regarding issues of concern to older Americans, to services development and system-building.

(4) The existing program design for determining the impact, effects, cost, replicability, and transferability of demonstrations is implausible.

(5) The existing program design for achieving utilization of research in the public policy formation process is likely to produce inconsistent results.

(6) The existing program design for AoA's support of the evaluation function throughout the network is implausible.

(7) Staffing and intramural capacity in research, demonstration, and evaluation, education and training program management is a serious problem at AoA.

(8) Continued progress in research, demonstration, and evaluation planning is needed, so that the role of both in support of all of AoA's mission elements can be made more demonstrable.

(9) Concentration of title IV research and training funds is also a significant issue. (Measures of investment adequacy are needed; as are appropriate strategies for concentrating resources sufficiently to achieve visible results.)

Appendix 2

REPORTS FROM FEDERAL DEPARTMENTS AND AGENCIES

ITEM 1. DEPARTMENT OF AGRICULTURE

FEBRUARY 23, 1981.

DEAR MR. CHAIRMAN: Thank you for your committee's letters to Secretary Bergland and Mr. Alex P. Mercure requesting an update of the U.S. Department of Agriculture (USDA) activities in the fiscal year 1980, affecting older Americans.

We are pleased to submit the following report. Enclosed is input from the following USDA agencies for inclusion in the "Developments in Aging" report: (1) Science and Education Administration; (2) Forest Service; (3) Economics and Statistics Service; (4) Rural Electrification Administration; (5) Farmers Home Administration; (6) Food and Nutrition Service, and (7) Office of Equal Opportunity.

We hope this information will be helpful both to the committee and to others concerned with the welfare of older Americans Thank you for giving us the opportunity to be included in the annual report, "Developments in Aging" of the Senate Special Committee on Aging.

Sincerely,

JOHN R. BLOCK, *Secretary.*

Enclosure.

SCIENCE AND EDUCATION ADMINISTRATION

It is estimated that approximately $18 million (25 percent) of all resources in Extension family education programs directly or indirectly provide program activities regarding the elderly.

Extension, Science and Education Administration, USDA, is a party in two of AoA's working agreements for older people: (1) *Working agreement on information and referral for older people;* (2) *working agreement on energy conservation actions for the elderly.* Extension, in addition, has a (3) *memorandum of understanding with AoA to improve the quantity and quality of nutrition, health, and other supportive services to older persons.* (4) *Educational programs* to meet the above needs and the myriad other needs and interests of the elderly are provided by national, State, and county Extension professionals, Extension Homemaker Club members and 4-H and other youths.

At State levels these are goals for programs aimed especially to the elderly: Knowledge of laws and regulations affecting the family/household (i.e., credit, consumer protection, property descent, divorce, employment, day care, social security, medicare, death and burial, etc.); knowledge of where health services are available and how to use these services appropriately; helping people participate in health services and continue to learn what constitutes and contributes to wellness, referral for available health services; developing programs for persons facing major economic and/or social adjustments, such as divorce, displacement, death of a spouse, or family abuse; providing programs that help develop skills for remaining self-sufficient in the retirement years; and increasing involvement by families in public decisionmaking which impact directly on designated populations.

Extension staff members cooperate with many other agencies and organizations in efforts to meet the interests and needs of the elderly. At the national level, major coordination is with AoA, National Endowments for the Arts and Humanities, AARP–NRTA, NCOA, the National Safety Council, the National Extension Homemakers Council, and the White House Conference on Aging scheduled.

HUMAN NUTRITION PROGRAM IN AGING

A major new national facility for the study of human nutrition in aging is being constructed at a cost of $23 million on land donated by Tufts University. Construction is scheduled for completion in 1982. At that time research will be conducted into the ways in which diet, alone and in association with other factors, can delay or prevent the onset of the degenerative conditions commonly associated with the aging process. Research programs developed in the center will identify nutrient requirements during aging and the ways in which an optimal diet, in combination with other factors—heredity, constitutional, psychological sociological, and environmental—may contribute to health and vigor over the lifespan of people.

During fiscal year 1980 the Human Nutrition Research Center on Aging at Tufts University was appropriated $2 million. Using facilities made available by Tufts University, an interim research program is developing. Studies to determine the significance of dietary protein in maintaining tissue function as aging takes place, as well as more fundamental studies of the effect of nutritional status on individual cells through life, are in progress. In addition to these studies, significant progress has been made in developing a program of nutrition evaluation of older Americans.

Forest Service

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The U.S. Department of Agriculture, Forest Service in cooperation with the Department of Labor sponsors the senior community service employment program (SCSEP). The SCSEP provides part-time employment, work experience, and skills training to economically disadvantaged seniors, aged 55 and older, who reside primarily in rural areas.

Program participants are involved in projects on national forest lands such as construction, rehabilitation, maintenance, and natural resource improvement work. Enrollees receive at least the minimum wage to supplement their personal incomes. A major benefit of the SCSEP program is the opportunity participants have to regain a sense of involvement with the mainstream of life through meaningful work. Additionally, valuable conservation projects are completed on national forest lands.

Our July 1, 1979 through June 30, 1980, interagency agreement (for fiscal year 1979) with the Department of Labor provided funding of $14.5 million to conduct the SCSEP in rural areas within 40 States and the Commonwealth of Puerto Rico. The SCSEP served approximately 3,947 seniors who accomplished approximately 2,208 person-years of conservation work valued at $20 million. During this program year, 28 percent of the enrollees were women and 17 percent of the enrollees were minorities. For each dollar invested in the SCSEP, an estimated $1.38 worth of conservation work was accomplished.

Our July 1, 1980 through June 30, 1981, interagency agreement (for fiscal year 1980) with the Labor Department provided funding of $15.4 million which maintained the program at the previous year's level. We anticipate serving 4,200 seniors; we expect that 32 percent will be women and 19 percent will be minorities. These senior workers should accomplish 2,250 person-years of conservation work valued at more than $21.2 million. For each dollar invested in the program, we anticipate reaping $1.38 worth of conservation work.

Economics and Statistics Service

The Economic Development Division, Economics and Statistics Service, for several years has had at least one study that considered the elderly directly. Several studies (those with relevant age categories as a set of variables) involved consideration of age along with other variables. Direct consideration has involved mainly the following individuals and reports:

E. Grant Youmans, Ph. D., EDD, ESCS, USDA. Stationed at University of Kentucky. Retired 1978.

E. Grant Youmans and Donald K. Larson. "Health Status and Needs: A Study of Older People in Powell County, Ky." Dept. of Soc., Univ. of Kentucky, cooperating with EDD, ESCS, USDA, RS-52, April 1977.

Donald K. Larson and E. Grant Youmans. "Problems of Rural Elderly Households in Powell County, Ky." EDD, ESCS, USDA, ERS–665, January 1978.

E. Grant Youmans. "Age Stratification and Value Orientations," Internat'l J. of Aging and Human Dev., vol. 4, No. 1, 1973, pp. 53–65.

E. Grant Youmans. "Age Group, Health, and Attitudes," the Gerontologist, vol. 14, No. 3, June 1974, pp. 249–254.

E. Grant Youmans. "The Aging: Needs and Services," Yearbook of Agriculture, 1971, pp. 197–200.

Mary Jo Grinstead-Schneider, Ph. D. Employed by University of Arkansas and working with Bernal L. Green, Ph. D., EDD, ESCS, USDA.

Doyle Butts, Mary Jo Schneider, et al. "Programs for the Aged in Western Arkansas: A Cost Analysis." Ark. Agr. Exp. Sta. cooperating with Western Ark. Area Agency on Aging and EDD, ESCS, USDA, Bul. 847, September 1980.

Michelle Davis Fryar, Mary Jo Schneider, and Donald E. Voth. "The Impact of Nutrition Programs on the Health Status of Elderly Arkansans." Ark. Agr. Exp. Sta. cooperating with EDD, ESCS, USDA, Bul. 839, October 1979.

Ann Tippitt, Mary Jo Grinstead-Schneider, and Bernal L. Green. "Problems and Adjustments to Loss of Spouse Among the Elderly: Fort Smith and Waldron, Ark." Ark. Agr. Exp. Sta. cooperating with EDD, ERS, USDA, Bul. 823, 1977.

Alan May, et al. "An Evaluation of Congregate Meal Programs and Health of Elders: Scott County and Fort Smith, Ark." Ark. Agr. Exp. Sta. cooperating with EDD, ERS, USDA, Bul. 808, July 1976.

Alan May, et al. "Attitudes Toward Nursing Homes and Other Facilities for Meeting Health Care Needs After Retirement: Scott County and Fort Smith, Ark." Ark. Agr. Exp. Sta. cooperating with EDD, ERS, USDA, Bul. 800, June 1975.

Nelson LeRay, Ed. D., EDD, ESCS, USDA Stationed at University of New Hampshire. Retired 1980.

Nelson LeRay and Donn A. Derr. "Community Service Convenience and Satisfaction of the Elderly in Nonmetro Areas of the Northeast," J. of the Northeastern Agr. Coun., VI, April 1980, pp. 67–80.

Nelson LeRay, et al. "Community Services for Older People in the Rural Northeast." Northeast Reg. Ctr. for Rur. Dev. Pub. 14, Ithaca, N.Y.: Cornell Univ., July 1978, pp. 135–144.

Nelson LeRay, et al. "Elderly Households in the Nonmetropolitan Northeast and Their Satisfaction With Community Services." New Hampshire Agr. Exp. Sta., Univ. of New Hampshire, cooperating with EDD, ESCS, USDA, Res. Bul. 646, March 1977.

Nelson LeRay, et al. "Household Income Status of the Elderly in New Hampshire." New Hampshire Agr. Exp. Sta., Univ. of New Hampshire, cooperating with EDD, ERS, USDA, Res. Rpt. 23, April 1972.

James R. Bowring and Nelson LeRay. "The New Hampshire Older Poor." Coop. Ext. Ser. Univ. of New Hampshire, Ext. Cir. 398, June 1969.

Robert A. Bylund, Nelson LeRay, and Charles O. Crawford. "Older American Households and Their Housing 1975: A Metro-Nonmetro Comparison." New Hampshire Agr. Exp. Sta. Univ. of New Hampshire, cooperating with EDD, ESCS, USDA, AE and RS 146, January 1980.

Nelson LeRay, et al. "The Older Population of New Hampshire." New Hampshire Agr. Exp. Sta., Univ. of New Hampshire, cooperating with EDD, ESCS, USDA, Res. Rpt. 66, July 1978.

Robert Bylund, Charles O. Crawford, Nelson Leray, and Elinor M. Caravella. "The Rural Elderly in the United States and the Northeast: A Statistical Report." Northeast Reg. Ctr. for Rur. Dev. Pub. 14, Ithaca, N.Y.: Cornell Univ., July 1978, pp. 14–31.

Janet W. Coffin and Nelson LeRay. "Older Farm Operators and Their Farms." EDD, ESCS, USDA, Working Paper 7910, December 1979.

Nina Glasgow, M.A., EDD, ESS, USDA.

Andrew J. Sofranko, Frederick C. Fliegel, and Nina Glasgow. "Older Urban Migrants in Rural Settings: Problems and Prospects," Internat'l J. of Aging and Human Dev. (forthcoming 1981).

Nina Glasgow. "The Older Metropolitan Origin Migrant as a Factor in Rural Population Growth." Rebirth of Rural America: Rural Migration in the Midwest.

Ed. Andrew J. Sofranko and James D. Williams. Ames, Iowa, North Central Reg. Ctr. for Rur. Dev., Iowa State Univ. 1980, pp. 153–169.

Donald K. Larson, Ph. D., EDD, ESS, USDA.

Donald K. Larson. "Elderly Americans: Emerging Economic Issues," Proceedings of Science and Aging, 1976.

Donald K. Larson. "Rural Elderly: Needs, Problems, Satisfactions," Rural Development Perspectives, No. 1, November 1978, pp. 21–22.

For coauthored reports, see Youman's publication list.

RURAL ELECTRIFICATION ADMINISTRATION (REA)

REA-financed electric and telephone systems must provide service to all residents of the areas they serve. Upon request REA does provide the REA borrowers with information about Federal financing and technical assistance available to help the elderly.

The most recent community development survey reveals that a number of the electric and telephone systems which are financed by REA are working with other community leaders on various projects for the elderly, i.e., housing, medical, transportation, and food distribution.

Although REA does not have the exact number, many elderly citizens are receiving home energy audits and other assistance from the electric cooperative to help save energy.

FARMERS HOME ADMINISTRATION (FMHA)

1. SECTIONS 502 AND 504 RURAL HOUSING LOANS

Section 504 rural housing loans are available to qualified low-income applicants to make basic repairs necessary to remove health and safety hazards. This includes such items as roof repair, storm windows, and doors, insulation, water systems, and waste disposal systems. The maximum loan is $7,500 and the interest rate is 1 percent. For the fiscal year 1980, $24 million is available for 504 loans. For elderly applicants who do not have repayment ability for a 1-percent loan, grant funds may be available for necessary improvements; $24 million is available in fiscal year 1980 for the grant program. This compares with $19 million available in 1979.

Elderly applicants may also be assisted under the section 502 loan program. Such loans are available to build, purchase, or rehabilitate modest homes that are adequate to fit the needs of the applicant. The interest rate on section 502 loans is currently 13 percent, with a maximum repayment period of 33 years. For low-income applicants, reduced interest rates are available to as low as 1 percent depending on income, number of people in the household, amount of loan installment, real estate taxes, and property insurance. Seventy-two percent of $3,080 billion available for section 502 loans in fiscal year 1980 is allocated to applicants who will qualify for the reduced interest rates.

Farmers Home Administration regulations are currently in process of revision to clarify the provision to allow for adequate space to include elderly family members, such as parents or grandparents, as a part of the household.

2. SECTION 515 RURAL RENTAL HOUSING

Rural Rental Housing

The section 515 rural rental housing program provided approximately 31,000 units for $868 million in loan obligation during fiscal year 1980. Of this amount, it is estimated that 30 percent was expended to house the elderly. Many of these units were subsidized with FmHA rental assistance or by Department of Housing and Urban Development (HUD), section 8 assistance payments. As of this writing, FmHA has not completed its program evaluation relative to assistance impact. Therefore, the figures given are solely estimates and should be considered as such. Under these programs, low-income elderly households pay up to 25 percent of their adjusted income for housing, including utilities. If their adjusted income is too low for them to pay the established rent, these subsidies make up the difference.

For fiscal year 1981, FmHA has budgeted $918 million for rural rental housing coupled with an additional $403 million for rental assistance. FmHA also expects to receive from HUD 10,000 units of section 8 set-aside funds to be used with the rental housing program.

The FmHA State Directors will be working on a State-by-State basis with their HUD counterparts to determine the ratio of elderly units to family and large family units to be subsidized by section 8 assistance.

Congregate Housing for the Elderly and Handicapped

Farmers Home has authority under the section 515 rural rental housing program to build congregate housing for the elderly and handicapped. Congregate housing is an alternative for the elderly who need an assisted residential living environment. It offers the functionally impaired or socially deprived but not ill elderly residential accommodations with supporting services to assist them in maintaining, or returning to independent or semi-independent lifestyles to prevent premature or unnecessary institutionalization as they grow older. The regulations provide for the establishment of the following mandatory services: Meals, personal care and housekeeping services, transportation, and social and recreational activities. Developers who apply to Farmers Home for loans to build congregate facilities must demonstrate their ability to provide these minimum services. In most instances, developers are coordinating with social service agencies to obtain support in the provision of services.

The congregate housing for the elderly and handicapped program has been launched through a joint demonstration effort with the Administration on Aging of the Department of Health and Human Services (HHS). Farmers Home set aside $12 million for the construction of a congregate facility in each of the 10 HHS regions and two Indian reservations and the Administration on Aging provided up to $85,000 per facility for the support services named in the regulations. Sites were chosen based on the percentage of persons 60 years of age and older, income factors, and poor housing conditions. Housing will be constructed in Port Gibson, Miss., Mayville, N.Y., Baldwin, Mich., Onancock, Va., Truth or Consequences, N. Mex., Lamoni, Iowa, Wagner, S. Dak., Beaumont, Calif., Baker, Oreg., Carroll County, N.H., Turtle Mountain Tribe in North Dakota, and White Earth Tribe in Minnesota. Funding from the Administration on Aging for services will be available each year of the 3-year demonstration period after which the appropriate area agencies on aging have made commitments to continue the established services.

Farmers Home and the Administration on Aging have received technical assistance from the International Center for Social Gerontology (ICSG) through training and consultation to national and field office staffs. Farmers Home has funded ICSG to evaluate the project through a subcontract to the American Institute for Research. The Administration on Aging has provided funds for ongoing technical assistance to the projects over the demonstration period.

States such as West Virginia and Missouri have begun to replicate the demonstration effort through cooperative activities between social services agencies, FmHA State offices, and the developers.

3. POLICY COORDINATION AND TRAINING UNIT

An interagency agreement was signed by Alex Mercure, Under Secretary of Agriculture for Small Community and Rural Development, U.S. Department of Agriculture on August 1, 1980, for the purpose of conducting rural miniconferences in connection with the 1981 White House Conference on Aging. The purpose of the agreement was to provide for the orderly transfer of funds to the U.S. Department of Labor, Employment and Training Administration, in order to provide for the conducting of six rural miniconferences.

National Green Thumb, Inc., a title V Older Americans Act contractor with the Employment and Training Administration of the U.S. Department of Labor, was designated by Jerome Waldie, Executive Director of the 1981 White House Conference on Aging, as the convener for one or more rural pre-White House Conference "miniconferences" for the rural aging. The conferences were held in Owensboro, Ky., East Hartford, Conn., Jacksonville, Fla., Sioux Falls, S. Dak., Oklahoma City, Okla., and Sacramento Calif. These conferences involved older, rural citizens in meaningful discussions of their problems and concerns, and to enable these individuals to contribute policy and program recommendations for consideration in the 1981 White House Conference on Aging. The reports of the miniconferences will be submitted to the White House Conference on Aging Committee in Washington, D.C., as well as to the members of the technical committees which will be developing position papers on the issues to be discussed at the 1981 Conference. In addition, the White House Conference Committee will provide a copy of the rural report to the Conference delegates in order to stimulate an awareness of rural concerns prior to their meeting.

The miniconferences were funded by six Federal agencies. The following Federal agencies provided funds to support the miniconferences and the specific amounts by each are as follows:

Appalachian Regional Commission	$5,000
Department of Health and Human Services, Health Care Financing Administration	15,000
Department of Health and Human Services, Health Services Administration	15,000
Department of Housing and Urban Development	20,000
U.S. Department of Labor	40,000
U.S. Department of Agriculture	40,000
Total	135,000

Report of the National Strategy Conference

A national strategy conference on improving service delivery to the rural elderly was held in Des Moines, Iowa, on January 28 to February 2, 1979. This week-long conference was funded by FmHA and coconvened by the Iowa Lakes Area Agency on Aging and the National Association of Area Agencies on Aging. Its primary objective was to "identify not less than 50 persons with expertise in the various areas of rural service delivery and to bring these individuals together for an extended period to develop a strategy and working plan for improving service delivery mechanisms."

The conference attendance was limited to one delegate and one alternate from each State, plus representatives of Federal agencies and national associations. More than 118 persons participated at some point during the week.

Presently, FmHA is distributing the report of the national strategy conference which summarizes the problems that were discussed at the Des Moines conference and the primary strategies that were developed. It is organized around the seven fundamental subject areas—transportation, health, housing, nutrition, outreach, income/employment, and management/administration that were highlighted in the conference agenda.

The report of the national strategy conference will be distributed to the 1981 White House Conference delegates and State coordinators for consideration and deliberation. In addition, copies of the report are being distributed to Administration on Aging network and the participating organization of the conference.

Community Facilities Loan Division—Loan Payments That Impact on the Elderly

Community facility loans are made to public entities and nonprofit corporations in rural areas and towns not to exceed 10,000 people.

These loans are made to construct, enlarge, or improve hospitals, clinics, nursing homes, community buildings, fire stations, or other community facilities that provide essential service to rural residents and to pay necessary costs connected with such facilities.

Loans are made at 5 percent and may be amortized up to 40 years.

Nursing Homes

In fiscal year 1980, approximately 23 loans were obligated for nursing homes for some $24 million. These loans were in approximately 15 to 20 States. Nursing homes directly impact on the elderly in that they are almost wholly occupied by the aged.

Hospitals

Approximately 60 loans were made in fiscal year 1980 for hospitals. This amounts to approximately $70 million, and represents loans in almost 30 States.

Health Clinics

During fiscal year 1980, 102 loans were made for health clinics. These clinics were either for medical or dental services. The amount of funds loaned amounted to $37 million. Of the 102 health clinics, 83 were made under a joint agreement with the Department of Health and Human Services (HHS). These clinics are located in rural communities that are medically underserved. The HHS grants cover only operating expenses of rural health care projects, while FmHA loans cover the cost of construction, enlarging, extending, or otherwise improving and equipping of community nonprofit health facilities.

Miscellaneous Projects

Miscellaneous projects include those facilities such as medical rehabilitation centers, nutritional centers, and vocational rehabilitation centers. During fiscal year 1980, 26 such loans were made for approximately $7 million.

Interagency Agreement

In the State of Missouri, FmHA and the Missouri Division of Aging have entered into an agreement which encourages and fosters coordinated efforts between the two agencies to provide better service to the elderly in this State.

The objectives of this agreement are: (1) "Development of a facility for a comprehensive delivery of services to the elderly, located in a rural area." (2) "Joint initiatives and coordinated efforts to develop better coordinated services and more innovative programs to meet the needs of rural elderly."

There is also an agreement between one of the regional agencies on aging and FmHA district office in Missouri. Such efforts are also carried out in most other States on a less formal basis.

RURAL HOUSING SEC. 502 SENIOR CITIZENS, EMERGENCY, AND SELF-HELP LOANS OBLIGATED, FISCAL YEAR 1980 THROUGH SEPT. 30, 1980

State	Senior citizens loans				Emergency loans				Self-help loans			
	Initial		Subsequent		Initial		Subsequent		Initial		Subsequent	
	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount	Number	Amount
U.S. total	858	23,688,080	351	2,202,130	15	465,330	2	5,250	1,122	36,791,500	191	1,581,190
labama	56	1,474,830	14	59,110	0	0	0	0	18	438,840	17	27,910
laska	0	0	0	0	0	0	0	0	0	0	0	0
rizona	7	228,500	3	41,420	0	0	0	0	69	2,209,240	7	22,130
rkansas	65	1,526,370	22	124,530	0	0	0	0	41	1,105,680	11	12,680
alifornia	30	1,088,250	9	112,660	0	0	0	0	217	8,371,100	31	987,840
olorado	9	262,830	1	3,500	0	0	0	0	64	1,929,100	13	39,020
onnecticut	2	90,000	0	0	0	0	0	0	22	871,600	0	0
elaware	0	0	0	0	0	0	0	0	0	0	0	0
lorida	21	667,800	4	22,800	0	0	0	0	109	2,814,870	6	5,130
eorgia	8	158,910	12	78,960	0	0	0	0	0	0	1	593
awaii	28	1,254,120	0	0	0	0	0	0	0	0	0	0
daho	5	182,470	2	20,500	0	0	0	0	8	239,550	4	8,800
linois	1	27,400	6	28,770	7	258,880	0	0	1	5,890	1	1,000
diana	3	80,250	3	16,250	0	0	0	0	0	0	0	0
wa	21	667,130	10	55,100	0	0	0	0	0	0	0	0
ansas	4	48,400	2	4,310	0	0	0	0	0	0	0	0
entucky	28	798,270	9	52,040	0	0	0	0	0	0	0	0
ouisiana	45	1,460,200	7	19,710	0	0	0	0	0	0	0	0
aine	1	3,230	3	19,550	0	0	0	0	0	0	0	0
aryland	1	40,000	2	1,870	0	0	0	0	0	0	0	0
assachusetts	2	33,900	0	0	0	0	0	0	57	1,816,610	0	0
ichigan	5	150,030	11	79,240	0	0	0	0	12	360,950	2	2,540
innesota	1	30,500	3	23,350	2	63,000	0	0	7	292,490	8	13,480
ississippi	150	4,070,480	33	174,000	1	30,000	0	0	52	1,468,050	10	18,350
issouri	23	549,220	10	54,650	1	20,000	1	4,500	11	372,600	2	8,600

ntana	1	9,150	1	2,200	0	0	0	0	0	0	0	0
braska	5	108,920	1	3,000	0	0	0	0	0	0	0	0
vada	0	0	0	0	0	0	0	0	0	0	0	0
w Hampshire	0	0	0	0	0	0	0	0	31	1,264,000	1	40,000
w Jersey	1	29,000	0	0	0	0	0	0	0	0	0	0
w Mexico	7	210,610	2	8,000	0	0	0	0	43	1,256,300	6	115,250
w York	0	0	15	106,210	0	0	0	0	0	0	1	900
rth Carolina	25	732,180	21	129,700	0	0	0	0	23	633,860	7	14,490
rth Dakota	2	20,350	1	5,600	0	0	0	0	0	0	0	0
hio	6	194,700	1	2,300	0	0	0	0	0	0	0	0
klahoma	25	543,820	29	140,610	2	44,000	0	0	77	1,856,340	28	98,790
regon	13	515,880	11	125,810	0	0	0	0	21	934,540	12	127,130
ennsylvania	2	6,400	1	1,200	0	0	0	0	5	172,300	0	0
hode Island	0	0	3	14,090	0	0	0	0	0	0	0	0
outh Carolina	26	746,340	11	43,980	0	0	0	0	0	0	1	4,550
outh Dakota	2	2,500	2	16,400	0	0	0	0	59	2,122,350	2	35,570
Tennessee	38	832,710	11	34,050	9	0	0	0	3	86,100	0	0
Texas	91	2,267,410	8	44,360	0	0	0	0	28	676,530	1	24,810
Utah	4	123,500	1	17,500	0	0	0	0	0	0	0	0
Vermont	0	0	0	0	0	0	0	0	0	0	0	0
Virginia	41	1,124,010	32	190,670	1	950	1	750	7	225,100	9	30,930
Washington	7	188,460	7	111,370	0	0	0	0	79	2,846,000	7	19,300
West Virginia	30	785,310	10	73,680	0	0	0	0	0	0	0	0
Wisconsin	2	53,430	3	15,940	1	38,500	0	0	57	2,332,410	3	26,500
Wyoming	4	157,900	2	15,570	0	0	0	0	1	39,200	0	0
Puerto Rico	3	72,910	0	0	0	0	0	0	0	0	0	0
Virgin Islands	1	10,000	12	107,570	0	0	0	0	0	0	0	0
Western Pacific Territory	3	59,500	0	0	0	0	0	0	0	0	0	0

RURAL HOUSING SEC. 504 GRANTS OBLIGATED, FISCAL YEAR 1980 THROUGH SEPTEMBER 1980

State	Total amount	Rural housing sec. 504 grants			
		Initial		Subsequent	
		Number	Amount	Number	Amount
U.S. total	23, 999, 990	8, 013	23, 301, 350	576	698, 640
Alabama	692, 860	302	662, 880	24	29, 980
Alaska	33, 170	8	33, 170	0	0
Arizona	256, 390	56	252, 360	1	4, 030
Arkansas	670, 240	310	644, 530	26	25, 710
California	709, 480	171	687, 260	24	22, 220
Colorado	225, 480	67	214, 360	9	11, 120
Connecticut	79, 240	19	77, 840	1	1, 400
Delaware	140, 930	32	140, 930	0	0
Florida	657, 560	180	651, 050	7	6, 510
Georgia	899, 270	231	876, 010	21	23, 260
Hawaii	137, 610	64	133, 900	3	3, 710
Idaho	150, 210	55	150, 210	0	0
Illinois	776, 010	325	725, 310	42	50, 700
Indiana	396, 260	136	379, 540	11	16, 720
Iowa	403, 160	236	381, 440	23	21, 720
Kansas	295, 730	116	292, 810	2	2, 920
Kentucky	873, 040	286	860, 860	8	12, 180
Louisiana	812, 120	279	801, 360	7	10, 760
Maine	425, 030	142	404, 390	15	20, 640
Maryland	523, 650	139	504, 430	13	19, 220
Massachusetts	233, 080	69	221, 890	7	11, 190
Michigan	583, 230	199	562, 090	17	21, 140
Minnesota	331, 130	99	326, 860	3	4, 270
Mississippi	1, 072, 860	626	1, 019, 090	45	53, 770
Missouri	788, 590	406	747, 860	38	40, 730
Montana	85, 600	22	83, 660	2	1, 940
Nebraska	228, 850	97	220, 630	9	8, 220
Nevada	74, 350	22	71, 580	2	2, 770
New Hampshire	145, 120	44	130, 680	9	14, 440
New Jersey	267, 980	83	255, 320	11	12, 660
New Mexico	496, 130	121	490, 440	5	5, 690
New York	551, 810	197	528, 430	20	23, 380
North Carolina	902, 320	279	876, 540	20	25, 780
North Dakota	253, 170	70	249, 090	5	4, 080
Ohio	632, 830	147	611, 680	16	21, 150
Oklahoma	517, 170	198	502, 630	11	14, 540
Oregon	418, 980	123	394, 820	21	24, 160
Pennsylvania	868, 160	237	846, 820	16	21, 340
Rhode Island	80, 370	19	72, 680	6	7, 690
South Carolina	513, 170	147	501, 120	7	12, 050
South Dakota	181, 120	67	179, 020	2	2, 100
Tennessee	681, 450	185	680, 520	3	930
Texas	1, 193, 740	370	1, 180, 220	10	13, 520
Utah	96, 150	44	94, 310	2	1, 840
Vermont	247, 630	59	242, 620	4	5, 010
Virginia	504, 590	124	503, 990	1	600
Washington	302, 340	69	293, 420	8	8, 920
West Virginia	466, 480	180	449, 860	16	16, 620
Wisconsin	516, 860	134	493, 650	15	23, 210
Wyoming	60, 300	19	60, 300	0	0
Puerto Rico	1, 314, 220	336	1, 302, 120	8	12, 100
Virgin Islands	17, 210	4	17, 210	0	0
West Pacific Territory	215, 560	54	215, 560	0	0

FOOD AND NUTRITION SERVICE

The most recent tabulated data indicates that at least 1.350 million elderly persons (age 65 and older) are participating in the food stamp program. This figure is from November 1979. It is expected that participation by the elderly has increased since then, but studies to confirm this or indicate the extent of the increase are still in progress. Participation by the elderly has been increasing substantially since January 1979, when the food stamp purchase requirement was removed. Studies done since the elimination of the purchase requirement show that participation by households headed by the elderly increased by 32 percent from February 1978 to April 1979, while that of nonelderly households increased by 14 percent.

It is estimated that elderly persons received about $487 million in food stamp benefits in fiscal year 1980. This represents 5.6 percent of the total amount spent for benefits, approximately $8.69 billion. The average food stamp allotment per person, per month, was $34.11 as of September 1980. We do not have current figures for the average allotment which elderly persons or households receive.

We estimate that some 3.2 million elderly are eligible to receive food stamps. This rough estimate is actually the number of elderly who were below the poverty line in 1978 as given in the U.S. Census Bureau document, "Characteristics of the Population Below Poverty Level, 1978" (published June 1980). This number should be viewed cautiously for several reasons. First, it is based on 1978 data. Second, the Census figure does not count assets which can disqualify for food stamps, applicants otherwise eligible by income. Third, it does not subtract the number of elderly people in SSI cash-out States, who are categorically ineligible for food stamps. (SSI cash-out is explained later.)

Last, some elderly persons whose gross income is above the poverty line are eligible for food stamps because certain deductions can be subtracted from their gross income during the certification process. However, 3.2 million is as good an estimate as we presently have.

Especially in recent years, Congress and food stamp program administrators have been actively encouraging the elderly to participate in the food stamp program. Laws passed in 1977, 1979, and 1980, contained a number of special provisions aimed at easing participation for elderly persons and offering extra aid to households containing elderly members.

EASING APPLICATION

States must provide out-of-office interviews for *elderly* households who cannot or do not want to visit a certification office. Out-of-office interviewing can be done by telephone or by a prearranged home visit by an eligibility worker. Applicants may also designate an authorized representative to be interviewed for them, to obtain their food stamp coupons and to shop with their food stamps. Also, some project areas arrange transportation to certification and issuance offices as part of their outreach programs.

Elderly persons applying for or receiving supplemental security income can apply for food stamps at their Social Security office instead of at a welfare office. (*All* persons in the household must be applying for or receiving SSI or be processed at an SSA office.) SSI/food stamp joint processing is one of several attempts to make food stamps more familiar, acceptable, and available to the aged by coordinating the food stamp program with more widely used elderly aid programs. State agencies are also required to inform SSI and social security households about food stamps. This has most often been done through enclosures sent with SSI and social security checks and notices.

SPECIAL ELIGIBILITY CRITERIA

Elderly households can have twice the countable assets other households can before becoming ineligible for the program. Most households are permitted $1,500 in resources; a household of two or more persons which contains at least one person 60 years of age or older, however, can have assets up to $3,000 and still be eligible for food stamps.

Persons 60 years of age and older are not required to register for work.

Special deductions for medical and shelter costs are available for elderly people.

(a) All nonreimbursed medical expenses of a person 60 or older, which are over $35 per month (excluding costs for special diets), may be deducted from a household's income. (The threshold will be lowered to $25 and medical expenses of spouses of the elderly will be deductible in October 1981.)

(b) There is no limit placed on the excess shelter deduction which elderly households may claim. A household containing someone 60 or older may deduct all costs for shelter, which exceed 50 percent of its income after all other deductions. Other food stamp households may claim shelter costs over 50 percent of net income which, when combined with dependent care costs, do not exceed $115.

Households consisting entirely of elderly persons with very stable income can be certified for up to 1 year; the normal certification period is 3 months.

SPECIAL PROVISIONS FOR COUPON USE

Elderly persons and their spouses can use their food stamps to purchase meals at congregate eating facilities. Food stamps can buy meals served in senior citizens centers, senior citizen occupied apartment buildings, public or private nonprofit schools, and any other public or private nonprofit establishment that feeds senior citizens. Food stamps may also be used for meals at private establishments—including approved restaurants—which contract to sell meals to the aged at "concessional prices."

The elderly can use food stamps to buy prepared meals delivered to their homes by meals on wheels and similar organizations.

SPECIAL PROGRAMS

Two projects are being operated in conjunction with the SSI program in a number of sites to offer special aid to the elderly in obtaining nutritious diets.

An SSI "cash-out" program has been running in a few States since 1974. If States qualify and desire, they may add a fixed supplemental amount of money to all SSI checks instead of certifying eligible SSI recipients for food stamps. By law, the State must add at least $10 per month for single and two-person households out of its own funds; $10 is the minimum food stamp allotment for these households. By receiving aid in this way, elderly people are spared problems involved in certification and the embarrassment some feel in using food stamps. Currently, the only SSI cash-out States are California, Massachusetts, and Wisconsin.

A demonstration project, the SSI/elderly cash-out project, is now operating in seven States to test the feasibility and effectiveness of another method of cashing out food stamps for the elderly. Households consisting completely of persons 65 years of age or older, or persons receiving SSI benefits under title XVI of the Social Security Act, receive a check equal to the value of what their food stamp allotment would otherwise be. The check is issued by the State or local agency. The objective of this project is to try to increase the low participation of the elderly by removing perceived "participation barriers." These barriers are thought to include application procedures which are often difficult for the elderly or disabled, lack of transportation, and the "welfare stigma" associated with applying for and using food stamps. The effects on participation, nutrition, and administration will be evaluated to see if SSI/elderly cash-out should be implemented nationwide.

The demonstration project is operating in the following locations: Vermont (statewide), New York (one county), South Carolina (four counties), Ohio (one county), Minnesota (one county), Utah (statewide), Oregon (two regions; the area around Portland, and one other county), Virginia (one county).

FOOD DISTRIBUTION PROGRAM

USDA's substantial involvement in nutrition programs for the elderly funded under the Older Americans Act of 1965 and administered by DHHS, began in 1974. Since that time, the food distribution program (FDP) has played an important role in providing USDA-donated foods to the nutrition programs. Subsequent public laws amending the Older Americans Act have also altered USDA's role and responsibilities in providing food assistance. These amendments and their impact on the FDP are listed, in chronological order, as follows:

(1) Public Law 93-351, amending the Older Americans Act, was enacted July 12, 1974. This legislation set the minimum level of donated food assistance to the nutrition programs authorized under title VII of the act at 10 cents per meal, subject to annual adjustments for increased food service costs. It also required USDA to give special emphasis to purchasing high protein foods, meats, and meat alternates.

(2) Public Law 94-135, enacted November 27, 1975, amended the act to expand the food donation authority to maintain an annually programed level of food assistance to the title VII programs of not less than 15 cents per meal in the fiscal year ending on September 30, 1976, and not less than 25 cents per meal for the fiscal year ending on September 30, 1977. Applying the annual adjustment for increased food costs, this resulted in 16½ cents per meal for fiscal year 1976, and 27¼ cents per meal for fiscal year 1977. This legislation further provided, ". . . in any case in which a State has phased out its commodity distribution facilities before June 30, 1974, such State may, for purposes of the programs authorized by this act, elect to receive cash payments in lieu of donated foods . . ." Kansas was the only State eligible to qualify under this provision.

(3) Public Law 95–65, enacted July 11, 1977, extended the option for cash payments in lieu of donated foods to all States without regard to the termination of State food distribution facilities. The programed level of assistance was 29½ cents per meal in fiscal year 1978.

(4) With the enactment of Public Law 95–478, October 18, 1978, social service functions and the title VII congregate feeding program were integrated under an expanded title III program. In addition to the consolidation of services under this title, emphasis was included in the law to provide meal delivery services to the homebound elderly along with the continuation of congregate feeding. This law also called for the establishment under a new title VI, of nutrition services, comparable to those provided under title III, for older Indians that are represented by organizations of Indian tribes. The titles VI and III programs provide for both congregate and home-delivered nutrition services to persons aged 60 or older and their spouses. Both of these meal services are eligible for food donations or cash-in-lieu payments at the new legislated level of 30 cents a meal for fiscal years 1979, 1980, and 1981 as adjusted in the food-away-from-home series of the Bureau of Labor Statistics. Based on this adjustment, food donations or cash-in-lieu payments were provided on the basis of 38½ cents per meal in fiscal year 1979 and 43 cents per meal in fiscal year 1980. In fiscal year 1981, the programed level of assistance is 47.25 cents per meal.

FISCAL YEAR 1980 STATISTICS

In fiscal year 1980, 28 States elected to receive their entitlements in all cash payments. Five States elected donated foods only and 23 States chose to receive a combination of food and cash. This amounted to approximately $54.5 million in cash payments and $14.5 million in donated foods expended for fiscal year 1980.

USDA-donated foods or cash were provided to 1,178 nutrition programs with 12,475 sites serving an estimated 167.55 million meals. Of this number of meals, 163.23 million meals, or 97.4 percent, were eligible for USDA food assistance. The remaining 2.6 percent of the meals were served to program staff, visitors, and volunteers. The number of elderly and their spouses that were served through this program in 1980 was approximately 2.49 million persons.

In addition to the elderly nutrition programs administered by the Administration on Aging, USDA makes a limited variety of foods obtained through price-support activities available to public or private charitable institutions which may be serving senior citizens. Among the institutions which are eligible to receive food to the extent of the number of needy persons served are nursing homes, senior citizens centers, and meals-on-wheels programs not participating under the Older Americans Act. In 1980, charitable institutions received and served about $58.3 million of commodities to over 7,400 institutions which served an estimated 888,000 needy persons.

OFFICE OF EQUAL OPPORTUNITY (OEO)

Office of Equal Opportunity (OEO) provides leadership and direction to assure equal opportunity in USDA programs and activities. As part of this function, OEO monitors the civil rights compliance status of the various USDA agencies which administer federally assisted and direct assistance programs and activities. Specifically, OEO monitors agency compliance with the requirements of title VI of the Civil Rights Act of 1964 and other Federal nondiscrimination laws which prohibit discrimination on the basis of race, color, religion, handicap, or age. OEO monitors the requirements of these statutes in federally assisted programs, direct assistance programs, and employment programs of the Department.

The Age Discrimination Act (ADA) was enacted by Congress in 1975 as an amendment to the Older Americans Act. The Office of Equal Opportunity has responsibility for development of USDA implementing regulations. Although the ADA would appear to exclusively protect the elderly, its protections are extended to members of all age categories. Final USDA regulations implementing the ADA are expected early in 1981.

In May 1976, the provisions of the Age Discrimination in Employment Act (ADEA) of 1976 were extended to include Federal, State and local governments. The ADEA prohibits employment discrimination and protects persons between the ages of 40 and 75.

ITEM 2. DEPARTMENT OF COMMERCE

JANUARY 12, 1981.

DEAR MR. CHAIRMAN: Thank you for your letter requesting information for your annual report, "Developments in Aging." Enclosed are two copies of the report on activities relative to the aging which were conducted in fiscal year 1980 in the Department of Commerce.

In fiscal year 1980, this Department had a total identifiable expenditure of $7,104,000.

Sincerely,

PHILIP M. KLUTZNICK, *Secretary.*

Enclosure.

1980 REPORT ON AGING

The Department of Commerce currently has five bureaus that have programs that either directly or indirectly affect the elderly. Details of these programs are listed below by bureau:

BUREAU OF THE CENSUS

Statistical Reports

The following reports containing substantial amounts of data on older persons were issued by the Bureau of the Census in its "Current Population Reports" during 1980. The reports contain information about the demographic and socioeconomic characteristics of the population. Many of the "Current Population Reports" will be updated in 1981. Funding for these series is subsumed under general program expenditures and is not specifically identified.

Current Population Reports

Series P-20:	No.
Marital Status and Living Arrangements: March 1979	349
Population Profile of the United States: 1979	350
Household and Family Characteristics: March 1979	352
Geographical Mobility: March 1975 to March 1979	353
Persons of Spanish Origin in the United States: March 1979	354
Educational Attainments in the United States: March 1979 and 1978	356
Households and Families by Type: March 1980 (advance report)	357
Series P-23:	
A Statistical Portrait of Women in the United States: 1978	100
Nonvoting Americans	102
Families Maintained by Female Householders, 1970-79	107
Series P-25:	
Estimates of the Population of the United States by Age, Race, and Sex: 1976 to 1979	870
Estimates of the Population of the United States by Age: July 1, 1971 to 1979	875
Series P-27:	
Farm Population of the United States: 1979	53
Series P-60:	
Money Income in 1978 of Households in the United States	121
Illustrative Projections of Money Income Size Distribution, for Households, 1980 to 1995	122
Money Income of Families and Persons in the United States: 1978	123
Characteristics of the Population Below the Poverty Level: 1979	125
Money Income and Poverty Status of Families and Persons in the United States: 1979 (advance report)	125

Other Reports and Papers

Special reports and papers prepared by the Census Bureau include the following:

Preparation of a report on the "Demographic and Socioeconomic Aspects of Aging in the United States" based on the most recent available data, for publication in Current Population Reports, series P-23, continued.

A report on "Social and Economic Characteristics of Americans at Mid-Life" is being prepared for publication in Current Population Reports, series P-23.

A report on "Voting and Registration in the Election of November 1980" is being prepared for publication in Current Population Reports, series P–23.

J. S. Siegel's paper, "Recent and Prospective Demographic Trends for the Elderly Population and Some Implications for Health Care," was published in the Proceedings of the Second Conference on the Epidemiology of Aging, March 28–29, 1977 (sponsored jointly by the National Institute on Aging and the National Heart, Lung, and Blood Institute).

J. S. Siegel's paper, "Demographic Background for International Gerontological Studies," was accepted for publication in the Journal of Gerontology.

The Census Bureau is conducting research on ways of projecting mortality trends in the United States.

A paper on "The 1980 Census and the Elderly: New Data Available to Planners and Practitioners" was presented at the annual meeting of the Gerontological Society of America.

A paper on "Are the Elderly Residents of Sunbelt States Safer from Crime? A Tentative Answer from the National Crime Survey" was presented at the sixth annual National Victim Assistance Conference.

A paper on "Social Indicators of Aging" was presented at the annual meeting of the American Association for the Advancement of Science.

A paper on "Implications of Selected Structural Determinants on Use of Long-Term Care Facilities by the Aged" was presented at the Federal Statistical Users Conference.

A paper on "Structural Determinants of Institutional Use by the Aged: 1970" was presented at the annual meeting of the Gerontological Society of America.

A paper on "Direct Economic Costs of Criminal Victimization of the Elderly" was presented at the annual meeting of the Gerontological Society of America.

A paper on "Crime Against Elders: Factors Affecting Future Trends" was presented at the annual meeting of the Gerontological Society of America.

An address on the "Demography of Aging" was presented at the Federal Statistical Users Conference.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION

The National Weather Service of the National Oceanic and Atmospheric Administration (NOAA) publishes daily weather forecasts which are very useful to all citizens. Specifically, this information is extremely important to the elderly. The forecasts of severe storms, extreme heat, pollution index, floods, tornadoes, and hurricanes provide advance information which helps less mobile older citizens plan and act on ways to avoid predicted weather which could cause a crisis. For long range planning, NOAA's Environment Data Service (EDS) makes information available concerning weather trends in various regions of the country.

At the National Oceanic and Atmospheric Administration both the National Marine Fisheries Service (NMFS) and the National Ocean Survey (NOS) provide information that can be of importance to those retired citizens who wish to take part in marine recreational activities such as fishing and boating. Such information is supplied through recreation guides, charts, and other publications. Another NMFS publication is a monthly guideline pertaining to the "best buys" on fish for each geographic region. This informs the elderly of less expensive ways to fill their diet with high protein food.

The National Oceanic and Atmospheric Administration continues to provide indirect assistance to the aged. During fiscal year 1980, the related programs and estimated expenditure levels were determined by using the latest available Bureau of Census percentage of elderly to total population of 11.2 percent. Therefore, the following estimates were derived (in thousands of dollars):

Programs:	*Fiscal year 1980 expenditures*
Regional weather trends—local weather dissemination, air pollution, weather services, climatic data services, environmental documentation and information services	$2,904
Recreational guides—nautical chart services, marine recreation fisheries	1,115
Fish food guidelines—economic and commercial fisheries statistics, increasing use of resources, fishery products quality and safety	1,326
Total	5,345

PATENT AND TRADEMARK OFFICE

The Patent and Trademark Office continued the procedure that permits patent applications submitted by applicants who are 65 years of age or older to be "made special." This procedure allows the patent application to be taken up for examination earlier than its effective filing date would normally permit (section 708.02, Manual of Patent Examining).

There are numerous patents relating to drugs, disease prosthetics and other devices that have a greater impact on the elderly than on the general population, but these patents are a byproduct of the total examining process.

NATIONAL BUREAU OF STANDARDS

Fire Research and Safety

A fire safety evaluation system for health care facilities has been developed to determine if a hospital or nursing home has the level of fire safety protection prescribed in the National Fire Protection Association Life Safety Code. The value of this system is that it permits the provider to have more flexibility in selecting the fire protection features to use in attaining the required fire protection as compared with meeting each specification in the code. Use of the fire safety evaluation system permits the achievement of required fire protection at less cost, especially in upgrading existing buildings. It also gives the architect more flexibility in designing a building that better serves the needs of the residents, especially in new buildings and major renovations. It is hoped that this will mean less institutional-appearing nursing homes in the future.

A fire safety evaluation system for community based group homes for the developmentally disabled has been designed. There are no fire safety regulations that were designed for group disabled. This system will fill a well recognized void. The target population is composed mainly of mentally retarded citizens, with or without physical disabilities. The system is currently being field tested and extended to cover other types of board and care facilities.

Dental Materials

The work the Bureau has carried out over the past 50 years on dental materials and methods impacts the elderly, particularly the more recent work on polymer composite restorative materials. Other dental research at NBS which will yield major benefits for the elderly are: the development of new alloy ceramics and their fusing to base metals, and research into the deterioration of dental amalgams. The overall goal of these programs is to provide materials of greater durability and wear resistance and improved base metal alloy alternatives to the costly gold prostheses.

Synthetic Implants

Work in this program has produced the first implant standard for acrylic bone cements, three standards for new implant metals, reference materials for tissue compatability, several ASTM recommended test procedures, as well as major conferences on implant retrieval and analyses.

Listed below are the expenditures during fiscal year 1980 for these programs (in thousands of dollars):

Programs:	*Fiscal year 1980 expenditures*
Fire research and safety:	
Health care facilities	$250
Group homes for developmentally disabled	250
Dental	865
Synthetic implants	294
Total, NBS	1,659

NATIONAL TECHNICAL INFORMATION SERVICE

The National Technical Information Service is not involved in any programs for the elderly at this time. They do publish three special bibliographies which pertain to this subject. These publications primarily involve topics on social services, health, housing, and transportation problems. These documents are:

"Transportation for the Elderly of Physically Handicapped" (NTIS–PS–78/08[illegible]). This document contains abstracts of reports on transportation difficulties and designs as they relate to the aged and handicapped population. The source documents were submitted to NTIS by both Federal and non-Federal organizations.

"The Elderly (Social Health and Transportation Problems and Services)" (NTIS–PS–77/0672-volume I and NTIS–PS–78/0888-volume II).

These documents primarily treat topics on social services, health, housing, and transportation problems.

ADDENDUM

GENERAL ADMINISTRATION

In fiscal year 1980, the General Administration awarded a grant for $100,000 to the National Council on the Aging to help fund a Population Data Resource Center for Industry. The purpose of this center is to:

(a) Survey industry to determine the current corporate understanding of the impact of aging on their business.

(b) Encourage industry to assess its production patterns and marketing in light of the aging American population.

(c) Establish a systematic data collection, collation and analysis of pertinent aging information.

(d) Inform industry through quarterly newsletters, monographs, articles in trade publications and a national conference.

The center will study corporate attitudes towards gearing marketing strategies for aging Americans. It will also encourage industries to focus their production and marketing more towards aging markets through conferences and publications.

ITEM 3. DEPARTMENT OF DEFENSE

JANUARY 16, 1981.

DEAR MR. CHAIRMAN: This is in response to the letter from the chairman and ranking minority member, Senate Special Committee on Aging of October 30, 1980, which requested information on Department of Defense (DOD) actions and programs related to aging.

The DOD continues to operate a comprehensive retirement planning program for Defense Federal Service employees. Integrated into the overall personnel management process, our program is designed primarily to assist employees in their adjustment to retirement and to assist management in planning for replacement manpower needs. It encompasses extensive preretirement counseling for employees (and their spouses in many instances) on such subjects as financial planning, health needs, leisure time activities, living arrangements, and personal guidance; and includes trial retirement and gradual retirement options for employees where feasible. We believe our program helps alleviate many of the problems that employees have encountered in the past when approaching retirement age. We expect to continue the operation of this program in 1981.

The military departments and Defense agencies, in cooperation with community health officials, have continued to provide multiphasic occupational health programs and service to employees, and in some cases to former employees who have retired. Many of these programs and services are designed to address problems generally associated with increasing age. Included are health guidance and counseling, periodic testing for diseases and disorders, immunizations and treatments.

Within the Department active and continuing efforts are conducted to eliminate discrimination based upon age. These actions include the revision of internal regulations to assure that age is not used as a selection criterion or screening factor in any type of personnel action, and the continual examination of personnel policies, practices, and procedures for possible conflict with equal employment opportunity intent, including discriminatory use of age. These are continuing efforts.

In summary, the DOD has operated a comprehensive retirement planning program for civilian employees, provided extensive health care services to employees and carried out an ongoing, affirmative action program to preclude discrimination based on age. These program efforts will be continued in 1981.

Sincerely,

WILLIAM C. VALDES,
Deputy Assistant Secretary of Defense
(Civilian Personnel Policy).

ITEM 4. DEPARTMENT OF EDUCATION

JANUARY 14, 1981.

DEAR MR. CHAIRMAN: This is in further reference to your letter of October 30, 1980, requesting current information from the Department of Education to be included in part 2 of "Developments in Aging," the annual report of the Senate Special Committee on Aging.

In accordance with your letter, I am happy to enclose the updated material. An identical letter is being sent to Senator Domenici.

You will note that the Department no longer has the right to read program. The provisions of this program are now incorporated in the basic skills improvement program authorized under Public Law 95–561, the Education Amendments of 1978.

We have revised information for the following programs:

Vocational education
Community education
Adult education
Consumer education
Energy and education action center
Public library services to older Americans
Women's education equity
Indian education
Community services and continuing education
Captioned films and television

Moreover, three new programs have been added; they are basic vocation rehabilitation services, special projects serving the older blind population, and research and training centers.

If the Office of Legislation can be of further assistance, please let us know.

Sincererly yours,

ALBERT L. ALFORD,
Deputy Assistant Secretary for Congressional Services.

Enclosures.

INDIAN EDUCATION

The Indian adult education program is authorized by part C of the Indian Education Act, title IV of Public Law 92–318. Part C provides funds for special programs designed to improve educational opportunities for Indian adults. "Adult," as defined in the part C regulations, means any individual who has attained the age of 16. This includes the elderly.

The two programs operated under part C are:

(1) The planning, pilot, and demonstration program, for projects designed to test and demonstrate the effectiveness of programs for improving employment and educational opportunities for Indian adults.

(2) The educational services program, for the operation of projects that respond to local needs for improving educational opportunities for Indian adults.

Indian tribes, institutions, and organizations may apply for grants under both programs. State and local educational agencies may apply for grants only under the planning, pilot, and demonstration program, although priority in awarding grants under that program is given to Indian tribes and organizations.

In fiscal year 1980, $5,430,000 was available for grants under part C. Grants were awarded for 56 projects in 28 States to serve an estimated 10,000 Indians.

All grants went to Indian tribes and organizations. Grants ranged from $45,000 to $288,000 and were used to support a variety of activities, including:

—Basic educational skills training.

—Literacy programs.

—Programs to help Indian adults earn high school equivalency diplomas.

In fiscal year 1981, there will again be $5,430,000 available.

The Indian adult education program is administered by the Office of Indian Education in the Department of Education. The Office of Indian Education has recently funded a national survey of the educational needs of Indian adults. Results from that survey should be available early in 1981.

Technical assistance to improve the quality of adult education programs for Indians is available through five Indian education regional resource and evaluation centers.

COMMUNITY SERVICE AND CONTINUED EDUCATION PROGRAM

The community service and continuing education (CSCE) program under title I(A) of the Higher Education Act of 1965 (Public Law 89–329, as amended) provided funds to States and institutions of higher education for three purposes: to strengthen community service programs of colleges and universities; to support the expansion of continuing education in colleges and universities; and to support the expansion of resource materials sharing. The CSCE program was especially designed to meet the educational needs of adults who have been inadequately served by traditional education programs in their communities.

The State grant portion (90 percent of appropriated funds under this title) of the program was administered in each State by an agency designated by the Governor, under a State plan approved by the U.S. Commissioner of Education. The State agency established priorities and approved and funded institutional proposals. One-third of program costs were provided by non-Federal sources. The State grant program supported a number of projects designed to assist the older American. During 1979, more than 87,706 individual participants were involved in 82 projects in 29 States at a cost of $1,582,388 in Federal funds. Activities supported included programs to meet educational needs and interest of aging, legal aid and housing assistance, and programs providing training for professionals and paraprofessionals providing care and services to the elderly in multitopic areas.

Special projects, authorized by section 106, permitted the Commissioner to reserve 10 percent of the funds appropriated in order to support projects which were designed to seek solutions to regional and national problems brought about by a technological change. Such special projects were limited to demonstration or experimental efforts. Projects were based on a design for, and the implementation of, organized continuing education for adults.

In 1979, a renewal funding was awarded the Institute on Aging at Portland State University, in Portland, Oreg. This award of $67,000 continued work on a demonstration model to help solve work-related problems of middle-aged and older workers. The project identified alternative work roles and leisure options, developed a curriculum, tested and evaluated the processes, and synthesized and diffused the products nationwide. Total appropriations for the CSCE program fiscal year 1980 were $10 million. Of this sum $1 million was reserved by the Commissioner for special projects, with $9 million being distributed to the States. Ultimately, no special projects were funded because the funds reserved for them were rescinded by the Congress.

The Education Amendments of 1980, which reauthorized the Higher Education Act, amends title I to include most of the CSCE program as part of the new educational outreach program of part B. Through the education outreach program the Secretary of Education makes grants to the States to: conduct comprehensive postsecondary education planning, with particular emphasis on continuing education; develop and coordinate new and existing educational and occupational information and counseling programs; and support postsecondary continuing education programs for adults who have been inadequately served through traditional education opportunities. Institutions of higher education, public and private organizations, including business, industry and labor organizations, or any combinations of institutions and organizations are eligible to receive subgrants and contracts from States for information and counseling services and continuing education projects. One-third of the total program cost must be met from non-Federal funds.

COMMUNITY SERVICE AND CONTINUING EDUCATION PROGRAM FOR AGING AND OLDER ADULTS, FISCAL YEAR 1979

State and institution	Project title	Federal	Matching	Total
32 States, 79 institutions	82 projects	$1, 582, 388. 09	$1, 142, 317. 54	$2, 724, 705. 63
Arizona:				
University of Arizona				
Arizona State University	Arizona elderhostel	9, 260	4, 630	13, 890
Yavapai College				
Arkansas:				
University of Arkansas-Fayetteville.	Consumer problems of the elderly and related training.	10, 650	11, 100	21, 750
University of Arkansas-Little Rock, School of Law.	Planning for resource sharing legal services to the elderly planning project.	2, 118	23, 312	25, 430
California:				
Orange Coast College	When can I retire	2, 300	1, 150	3, 450
Columbia College	Model adaptation for comprehensive program development for older adults.	23, 000	20, 346	43, 346
University of California, San Francisco.	Intergenerational care-giving program.	50, 000	25, 000	75, 000
Modesto Junior College	Telecommunications for older adults.	40, 000	59, 126	99, 126
California State University, Chico.	Independent living skills for older adults.	60, 000	32, 425	92, 425
University of California, San Diego.	Public access cabletelevision for elders.	30, 000	15, 000	45, 000
Colorado:				
Arapahoe Community College.	The Emeritus College	7, 020	5, 460	12, 480
University of Denver	Mobilizing educational programs for older adults at senior facilities.	4, 431	4, 431	8, 862
Loretto Heights College	Statewide elderhostel project and establishment of elderhostel outreach.	25, 125	12, 589	37, 714
Connecticut, University of Connecticut.	Improving medication use behavior of the elderly by utilizing pharmacists as educators.	19, 429. 66	9, 713. 33	29, 142. 99
Delaware:				
Wesley College	Lifespan planning	11, 856	3, 052	14, 908
University of Delaware	Developing effective volunteer programs.	107, 913	35, 071	142,984
District of Columbia, University of the District of Columbia.	Closing the generation gap—an educational experience.	97, 518	66, 885	164, 403
Florida:				
University of North Florida.	Aging Studies Institute	20, 059	13, 090	33, 149
Florida JC at Jacksonville	Center for the Continuing Education of Senior Adults.	20, 760	17, 516	38, 276
Georgia:				
Berry College	Training program for workers who work with the elderly.	2, 851	1, 500	4, 351
University of Georgia	Assisting service providers to meet the personal care and self-actualization needs of older adults: A holistic approach.	24, 500	13, 168	37, 668
Illinois, DePaul University	Educational choices for older adults.	46, 436	24, 379	70, 815
Indiana, Indiana University, South Bend.	Preparing for the 1980's	20, 088. 43	10, 044. 21	30, 132. 64
Iowa, Cornell College	An ongoing chautauqua program for the senior adult.	9, 444	8, 759	18, 203
Kentucky:				
Georgetown College	Continuing education for the cultural enrichment of older persons in the Scott County area.	17, 265	9, 627	26, 892
Southeast Community College.	Assistance to programs for senior citizens in Harlan County.	20, 000	10, 000	30, 000
Western Kentucky University.	Multidisciplinary continuing education in applied gernontology for health personnel.	20, 000	11, 936	31, 936
University of Louisville	Citizen participation training for older persons.	20, 000	10, 000	30, 000
Morehead State University	Nutrition education for senior Kentuckians.	20, 000	11, 629	31, 629
Kentucky State University	Preretirement planning program.	20, 000	13, 528	33, 528
Thomas More College	Emeritus College	20, 318	18, 118	38, 436
Murray State University	Functional education for the aging in the purchase area.	16, 991	11, 423	28, 414

State and institution	Project title	Federal	Matching	Total
Maine, Westbrook College	Elder access to continuing education.	4, 668	7, 671	12, 339
Maryland:				
Maryland Consortium for Gerontology in Higher Education, Inc.	Maryland Elderhostel, 1979–80	12, 000	6, 454	18, 454
University of Maryland	Preretirement planning for disabled.	15, 440	8, 011	23, 451
St. Mary's College	Institution for liberal learning in retirement.	12, 378	15, 345	27, 727
Michigan: Oakland University	Career, personal and preretirement counseling for adults in university and community settings.	37, 000	20, 930	57, 930
Mississippi:				
Mississippi University for Women.	A career development program for women in the golden triangle.	18, 053	9, 964	28, 017
N.W. Mississippi Jr. College	Preretirement planning	23, 554	13, 000	36, 554
University of Southern Mississippi.	Elders Institute of South Mississippi.	20, 691	26, 046	46, 737
Missouri:				
East Central Junior College Union.	Senior citizen's service program.	5, 244	2, 622	7, 866
University of Missouri, Rolla	University of the third age	13, 918	6, 959	20, 877
Montana, University of Montana.	Estate planning assistance for Montana's senior citizens.	4, 300	2, 550	6, 850
Nebraska:				
Creighton University	Growing older—ways of coping.	10, 000	5, 832	15, 832
University of Nebraska, Omaha.	Workshops: Personal financial planning for retirement years.	19, 030	10, 008	29, 038
New Hampshire:				
Keene State College	Education for those working with the elderly.	4, 800	3, 200	8, 000
St. Anselm's College	Senior citizen representatives as resource advisors.	8, 500	4, 250	12, 750
New Jersey:				
Montclair State	Older adult assistance	28, 000	26, 434	54, 434
Rutgers University	Development of career ladders in gerontology.	32, 000	60, 823	92, 823
New Mexico:				
University of New Mexico	Mental health skill development for nursing home operators.	15, 000	8, 041	23, 041
New Mexico State University.	Training senior citizens to act as aides to handicapped.	17, 000	7, 558	24, 558
New York:				
SUNY, Oswego	Program to intervene in the cycle of intergenerational Unemployment and underemployment by improvement of math and reading skills.	35, 000	37, 460	72, 460
Brooklyn College, CUNY	Educational program for homemaker-home health aides.	35, 000	27, 884	62, 884
New York City Community College, CUNY.	Extending continuing education to the elderly homebound.	50, 000	51, 616	101, 616
North Carolina:				
University of North Carolina, Chapel Hill.	Horticultural therapy and continuing education for aged and disadvantaged.	16, 500	10, 519	27, 019
University of North Carolina, Asheville.	Office for Aging	23, 973	11, 987	35, 960
Mars Hill College	Health gerontology: Extension of education opportunities to the aging in Madison, Henderson, Buncombe, and Transylvania Counties.	19, 548	9, 774	29, 322
University of North Carolina, Charlotte.	Crime prevention workshops for senior citizens.	4, 208	2, 123	6, 331
North Carolina A&T State University.	Do-it-yourself weatherization techniques for low incomes and disadvantaged city dwellers.	8, 927	5, 000	13, 92/
North Dakota:				
Maryville State College	Physical education for the elderly.	14, 009	7, 004	21, 01.
Sinte Gleska	Continuing education for senior citizens.	13, 270	6, 635	19, 005
Tennessee, University of Tennessee, Martin.	Guiding older adults in health care assistance.	7, 000	2, 310	9, 310

COMMUNITY SERVICE AND CONTINUING EDUCATION PROGRAM FOR AGING AND OLDER ADULTS, FISCAL YEAR 1979—Continued

State and institution	Project title	Federal	Matching	Total
Texas:				
North Texas State University, Arlington.	Career service options for retired professionals.	14,500	11,600	26,100
Tarrant County Junior College District.	Senior citizen home health care training program.	13,000	6,500	19,500
University of Houston	Retirement planning	12,500	6,250	18,750
College of the Mainland	Focus on the future: Planning for retirement.	4,000	2,000	6,000
Hill Junior College	Enrichment program for senior citizens	4,000	2,000	6,000
Tarrant County Junior College.	Senior citizen home health care training program.	4,000	2,000	6,000
Texas Southern University	Internship assistance to State governmental agencies providing transportation for the elderly and handicapped.	4,000	2,000	6,000
Texas Tech University	Conference on current issues in gerontology—1980.	4,000	2,000	6,000
Utah, Dixie College	CSCE program for the aging and other neglected adults—phase VI.	5,500	2,750	8,250

BASIC SKILLS IMPROVEMENT PROGRAM

The basic skills improvement program is authorized under title II of Public Law 95–561. The basic skills program provides for instruction to children, youth and adults in reading, mathematics, and communication skills both written and oral.

In fiscal year 1980, the basic skills improvement program funded out-of-school projects designed to provide basic skills instruction to children, youth, and adults. Projects may serve older Americans as well as utilize the older Americans as tutors.

CONSUMERS' EDUCATION

The consumers' education program, authorized by title III, part E, section 331–336, of the Education Amendments of 1978 (Public Law 95–561), provides funds to stimulate in both school environments and community settings, new approaches to consumers' education efforts through competitive contracts and grants. These awards are used for research, demonstration, pilot projects, training, and the development and dissemination of information or curricula. In addition, funds may be used to demonstrate, test, and evaluate these and other consumers' education activities.

Fiscal year 1980 was the fifth funding year for this program and the Department of Education continues its support for projects addressing the consumer needs of the elderly—59 grants in 22 States plus the District of Columbia and the Trust Territories, were awarded to bring consumers' education to many diverse groups. Twelve of those 59 programs dealt extensively with meeting the consumer needs of the elderly. Some of the activities were directed toward developing a consumer education module tailored specifically to meet the needs of deaf senior citizen leaders; training seniors to become more effective advocates; developing an educational program designed to enable the elderly to maximize the efficiency of their home energy usage; and to make seniors knowledgeable about legal medicinal (generic) drugs.

ENERGY AND EDUCATION ACTION CENTER

The Energy and Education Action Center, established by the U.S. Office of Education (now the Department of Education) in collaboration with the Federal Interagency Committee on Education, serves as the point of focus for a Federal Government educational response to the challenges confronting schools and colleges created by emerging energy realities.

The general mission of the center is to promote all phases of energy education-related activities on an interagency basis by drawing upon all relevant, Federal, State, and local resources to assist educational clientele in implementing energy plans. This mission relates to the aging in three ways: encouragement, awareness, and assistance.

Because energy processes are so pervasive in our society, everyone benefits from energy education and awareness, whether it be preschoolers in a formal instructional setting, or young and old alike exploring energy concepts and demonstrations at community forums. Indeed, due to their fixed income status and higher vulnerability to certain types of illness, the elderly have an especially urgent need to learn energy conservation and cost avoidance techniques that are safe and effective, and to identify energy-saving products and practices which allow them to make lifestyle decisions that are desirable from a personal as well as societal standpoint.

Through workshops, telephone and mail inquiries, the Energy and Education Action Center provides technical and general information regarding energy conservation to contain costs through efficient use of facilities and through thermal efficiency. Questions, concerns, and suggestions are invited from any interested individuals or organizations.

METRIC EDUCATION PROGRAM

The metric education program, authorized by title III, section 312, of Public Law 95-561, provides grants and contracts to institutions of higher education and State and local education agencies and other public and private nonprofit agencies in order to prepare students to use the metric system of measurement. The system of weights and measures is used in everyday consumer activities, as well as in international commerce. In order to make effective consumer decisions and sound economic judgments, it is essential that all practicing parties fully understand the units by which goods and commodities are exchanged or purchased. For the most part, the elderly must live within fixed incomes. An effort to meet their educational needs in this regard is critical. One strategy used under the metric education program is to strongly encourage all grantees and contractors to incorporate and delineate techniques by which they will actually teach parents and other adults, including the elderly, to use the metric system as a part of their regular educational and training program.

PUBLIC LIBRARY SERVICES TO OLDER AMERICANS

Providing library service and information to aging persons is one of the priorities of the Library Services and Construction Act (LSCA); Department of Education (ED) program. This service, carried out by means of projects at the State and local level, is directed toward individuals as well as groups. ED provides assistance and functions in a coordinating capacity among governmental and nongovernmental agencies and groups at the national level to further the services of libraries to this age group.

Aging persons have used libraries and their information services just as any member of the public. In addition, the increasing number of persons in this age group and the growing awareness of their special needs have resulted in the development of particular programs and materials within the library, special information services, and outreach services to senior citizen centers, individual homes, and nursing homes. Libraries have been concerned with responding to the need for special services and the need to increase other agencies awareness of the value and breadth of the contribution which libraries are making and potential for greater involvement.

Federal money have been used to stimulate the purchase of talking books, large print materials, magnifiers, bookmobiles; and to pay for services such as home delivery, film programs, special seminars, outreach services to nursing homes and to other sites such as nutrition centers and senior day care centers. Though the 1973 amendments to the Older Americans Act included opportunities for strengthening library service to older adults through a new LSCA title IV, "Older Readers Services," this title was never funded. Services for the aging are provided from funds under title I, "Library Services."

Many successful programs in libraries are started with LSCA grants, frequently as demonstration projects, and then move to local funding as they prove their worth. North Carolina has used LSCA funds to start information and referral (I&R) services in local public libraries. As the local library takes over the funding, the next year's grant money goes to another location to start a similar project. One such endeavor, the Davidson Information Assistance Line (DIAL) has proved to be so important to the community that the sheriff's department answers the telephone service number after the library hours. Another I&R service in Pender County takes its program to the rural aging in its neighborhood information van.

Many aging persons find it difficult to get to the library, so the library finds ways to go to them. Outreach services such as bookmobiles for the aging, rotating and deposit collections for institutions and nursing homes, and personal delivery to the homebound bring needed materials and companionship to those unable to get out. Laurens and Lexington Counties in South Carolina have funded a 3-year demonstration project on outreach to the elderly that includes hiring two librarians to work full time with the programing for the aging. Other programs are coordinated by the library but are reliant on volunteers for the actual delivery of materials and conversation. The Snyder (Pa.) County Library program called VISITOR (volunteers insuring shut-ins the opportunity to read) and the James V. Brown Library's (Williamsport, Pa.) program called BRAVO (bringing reading to aging through volunteer organization) both rely on citizen helpers which include mobile senior citizens. In the BRAVO program, cooperation with other agencies that deliver services to the aging are stressed. The library coordinator for the program is experienced in Information and Referral work and has close ties to the rest of the social service community.

Using existing social, medical and nutritional support systems for the aging have frequently made LSCA funded projects more efficient. The Brooklyn (N.Y.) SAGE project (an already successful outreach program) found that it added 150–250 older readers when it "piggybacked" onto such programs as friendly visitor and meals-on-wheels. Another program that complements the LSCA funded efforts to serve the visually handicapped older readers is the Library of Congress system of loaning materials (such as braille and spoken tapes or records) through a network of 159 regional and subregional libraries for the blind and physically handicapped.

Other programs for those who cannot use conventional materials because of failing eyesight are frequently funded under LSCA. The Altoona (Pa.) Area Public Library records 60 minutes of features and news from the local newspaper each day and the cassettes are sent to those unable to read small newstype. Many libraries, like the Toledo-Lucas County Library, are increasing their large print collection and are bringing the awareness of the availability of the material to those in need of this service. Van delivery, bookmobile deliveries, and books-by-mail are used to get special materials to aging readers. Sites where those over 60 years of age gather also utilized by libraries for the delivery of materials and programs of special interest.

Programs on topics of interest to older citizens are given at the library as well as at nutritional sites, senior centers, nursing homes, churches, etc. The gray and growing programs by the Baltimore County Public Library are examples of programs that deal with improving the perceived value of life by the aging. Talks and audio-visual presentations are given on such accepted topics as health issues; art and crafts; reminiscences about the county fair, the 1920's, trains, and early Baltimore; and on controversial subjects such as sexuality and the aging. Many programs are jointly sponsored by the public library and other agencies interested in the problems of the aging. Seminars, such as the one on crime prevention sponsored by the New York Public Library, the Senior citizens crime prevention program, the New York City Foundation for Senior Citizens, Inc. and the department for aging of the city of New York, have been received good community support.

Programs vary by location and makeup of the community served. Local needs are assessed before programs are funded. One unique program for the aging is found in Hawaii. In this project most of the money for materials for the aging program are spent on foreign, especially oriental language books since a large percentage of the over 60 population are bilingual or foreign speaking and/or reading.

As the local public libraries become more aware of the need for services tailored for the older reader, and as they work with other groups and agencies that are also concerned with service to the aging; a greater understanding of what libraries are doing and what more they can do will be gained by all parties. To further this kind of understanding, the Department of Education takes an active part in the Interdepartmental Task Force on Information and Referral, and outgrowth of the White House Conference on Aging in 1971, which provides for coordination among Federal agencies involved in projects on aging and aging populations.

These examples illustrate the commitment among those bringing library service to the aging, to offer relevant materials, programs and information to the older library user; and in addition, to take library service to the elderly population that cannot come to the traditional library setting.

WOMEN'S EDUCATIONAL EQUITY ACT

The women's educational equity act program, authorized by title IX, part C of the Elementary and Secondary Education Act of 1978 provides funds for demonstration, developmental and dissemination activities designed to promote educational equity for women. The reauthorized act includes a new purpose—to provide financial assistance to local educational institutions to assist them in meeting the requirements of title IX of the Educational Amendments of 1972. Among the act's six authorized activities are programs to provide educational opportunities for adult women, including unemployed and underemployed women. The program seeks to address the diverse needs of various racial, ethnic, age, and regional groups; women and girls of all age groups are potential program beneficiaries.

During fiscal year 1979 and 1980 a variety of program models and materials were developed to facilitate the reentry of adult women into the academic or employment ranks. Some project activity, for example, focused specifically on business management and leadership training. Other projects have been structured to provide continuing education and training, including a variety of counseling strategies for displaced homemakers. These project activities continue the program's early emphasis, in its 1976 to 1978 grant activities, on adult women's educational needs. Products of these grants are available, at cost, from the WEEA Publishing Center, EDC, 55 Chapel Street, Newton, Mass. 02160 (800-225-3088).

ADULT EDUCATION

The Department of Education recognizes the rapid changes in the Nation's school age population and is moving toward the goal of ensuring equal educational opportunities for *all* citizens. While no Federal education program contains an explicit mandate relative to serving older persons, as the new Department moves in this direction and assists American education to adjust to socioeconomic demands, the elderly will become increasingly important.

Programs funded under the Adult Education Act, Public Law 91-230, as amended, are authorized to address the educational needs of all segments of the eligible adult population in a State. In these State-administered programs special emphasis is given to meeting the educational needs of older persons. In compliance with the basic purpose of the act, highest priority is given in each State's 3-year plan to those adults who are least educated and most in need of assistance. Formula grants are awarded to the 57 States and outlying areas to support basic education programs for out-of-school adults age 16 and over, and to assist them in continuing their education through completion of the secondary level. Individuals participating in the program are expected to acquire the basic skills and knowledges necessary to function in society, to secure training which will help them to become more employable, and to carry out their citizenship responsibilities in American society.

The grant formula is based on the number of adults in a State without high school diplomas who are not currently required to be enrolled in school. Federal funds support up to 90 percent of each State's program and up to 100 percent of the programs in outlying areas. At least 10 percent of each State's allotment must be used for special experimental demonstration projects and teacher training.

In addition to the State-administered program, the act authorizes educational programs for adult immigrants and adult Indochina refugees, planning grants to States, and a national development and dissemination program. Funds have not been appropriated to implement the last two provisions.

There are approximately 57 million adults in the United States 16 years of age and older who have not completed the secondary level of education, and are not required to be enrolled in school. It is not known how many adults who have completed the secondary level but are not functioning at that level. This group is also a major part of the target population.

The Adult Performance Level Study, funded by the Division of Adult Education, provided significant findings concerning the functional level of the adult population. The APL study reported that the largest percentage of persons who were functionally incompetent (35 percent) or were only marginally competent

(40 percent) were older persons 55 to 65 years of age. Persons older than 65 were not included in the study. (Adult Functional Competence: A Summary, Adult Performance Level Project. The University of Texas, Austin, Tex., March 1975, p. 7).

This age group also has a high turnover. Studies indicate that, "everyday only 5,000 Americans reach 55, and an estimated 3,600 persons die. The net increase is about 1,400 a day; or a half a million a year." Some of these adults are in mental and correctional institutions, boarding homes, hospitals, and many are homebound in high risk urban centers or in remote rural areas. All are isolated from their families and friends, and have limited access to education and other essential services.

Title XIII, part A of the Education Amendments of 1978, extends and revises the Adult Education Act and creates new program initiatives to improve and strengthen educational services to eligible adults, including older persons. The principal goal of the amendments is to expand a State's current delivery system of adult education, and to broaden outreach activities. States may award subgrants to public and private nonprofit agencies, in addition to funding local educational agencies. In implementing the structural and programmatic changes created by the 1978 amendments to the act, increased attention by the States is placed on serving older persons with limited English language skills. Opportunities for significant expansion of the delivery of adult education services are provided through cooperation with agencies, institutions, and organizations other than the public school systems such as, business, labor unions, libraries, institutions of higher education, public health authorities, antipoverty programs, and community organizations. States have instituted strategies to ensure the involvement in the development of the 3-year State plans for business and industry, labor unions, churches, public and private educational agencies and institutions, fraternal and voluntary organizations, community organizations. State and local manpower and training agencies, and representatives of special adult populations. States have developed special methods and techniques to increase their efforts in informing the adult populations who are least educated and most in need of assistance of the availability and benefits of the adult education program.

In order to ensure the participation of these adult populations, recipients of funds are required to provide reasonable and convenient access to the program. Programs must be more flexible in their course offerings, locations, and in terms of assuring the availability of support services such as day care and transportation.

Departmental activities in 1980 as well as in 1979 have continued to center around assisting the States in implementing the administrative changes required by these amendments to the act. Attention is focused on assisting the States in improving State participatory planning strategies, programs development, monitoring, coordination or integrated use of resources from multiple funding, sources, and evaluation.

Older persons were included in the participatory planning activities for the preparation of the 3-year State plans, and are continuing their involvement in State plan development and evaluations.

Some States have negotiated and implemented interagency agreements with State and area agencies on aging, and with other related agencies and institutions serving older adults. Other States are encouraged to consider this administrative strategy. Technical assistance services and resource materials are providing the States to help strengthen their capacity for program development in carrying out such process requirements as needs assessment, planning, monitoring, coordination and evaluation. Two major program initiatives were undertaken in the transportation and telecommunications fields. Some significant developments are described below.

The establishment of coordinated State systems of education and transportation services is encouraged. A national task force for this purpose was convened to give guidance and direction to this activity on the Federal level, and three regional meetings approved to be held in three cities—Jacksonville, Detroit, and Denver—for State directors and appropriate representatives of agencies and community-based organizations in Regions IV, V, and VIII. It is through this intergovernmental planning mechanism and process that States are assisted in establishing priorities, and to invert Adult Education Act resources in a coordinated or integrated agency services system reaching older persons and the handicapped.

The White House Conference on Aging in 1971 recognized that, "educational efforts on behalf of older persons are less effective without attention to *outreach* and the improvement of accessibility through the removal of *transportation* barriers." A strategy for technical assistance intervention was the development of interagency agreements between the Administration on Aging and the Office of Education. In 1979 the revised agreements included the Department of Transportation, ACTION and the Community Services Administration. Guidelines for planning the establishment of transportation services for older persons through the use of cooperative strategies and processes resulted from five demonstration projects sponsored by DHEW, DOA, GSA, DOL, DOT, ACTION, and the Community Services Administration. Education agencies were not participants in these projects on any level. The extension of intergovernmental agency effort will be needed nationwide to help them in the planning of procedures to link education into future coordinated transportation services systems.

The first regional coordinated education/transportation services workshop was held on the site of one of the five projects, in Jacksonville, Fla., for State participants in Region IV (South Carolina, North Carolina, Kentucky, Georgia, Florida, Tennessee, Mississippi, and Alabama). These States have large older populations comprising 11 percent and over of the total population, with over one-fifth of the persons 65 years and over below the poverty level. Many of the aged poor in these States live in isolated rural areas and inadequate transportation is one of the major problems preventing access to educational and other services. The State of Florida has enacted chapter 427 of the Florida statutes establishing a coordinating council to foster coordination of transportation services provided to the "transportation disadvantaged." The definition of the "transportation disadvantaged" include "individuals who because of age are unable to transport themselves, to purchase transportation and are, therefore, dependent upon others to obtain access to education or other life sustaining activities."

This model State statute, requiring coordinated transportation services for the aged and other special populations is being widely distributed for other States to consider for legislative action. The North Carolina adult education program reproduced the technical assistance packet distributed at the regional meeting, and under section 310 of the act is funding two projects in a rural and urban area to demonstrate ways adult education agencies can provide coordinated transportation services to adult students. It was recognized early that educational agencies cannot provide this support service alone.

The adult education program in the State of Mississiopi is budgeting for the use of existing transportation services in the districts, including support of special buses and carpools.

Efforts are also underway to help the States to: (1) Increase the availability of resources for use in rural transportation services; (2) create a program that will provide technical assistance to (a) community based organizations and local governments administering adult education and transportation programs, (b) increase access to educational programs for adults statewide; (3) facilitate coordination of resources and overcome barriers to the implementation of transportation services for adults needing them.

In the area of research, the National Task Force is following the progress of two ongoing projects relating to transportation for the elderly, and supported by the Office of University Research, Department of Transportation, Shaw University in Raleigh, N.C., is investigating the use of schoolbuses for transporting the elderly and nonwheelchair handicapped persons during off-peak hours, including the legal and institution barriers to such use. In the second project, the Transportation Training and Research Center of Polytechnic Institute of New York is nearing completion of a study to develop a methodolgy for evaluating existing and new transportation services with respect to meeting the travel needs of the elderly and handicapped, and to develop suggested service standards for different types of handicaps. While the latter terms of the project are directed to the handicapped, the findings offer promise for applicability of the standards. According to studies by the Department of Transportation, more than one-third of the elderly are handicapped and will benefit from these activities.

Telecommunications technologies are also being examined to determine their potential applications as a means for outreach and as an alternative system for the delivery of educational programs and services to adults for whom this program is intended. Many older adults can be helped to overcome the disadvantages imposed by living in remote rural areas, and institutions, by being homebound or isolated from social supports essential to meet their daily needs. A collaborative relationship now exists between the program and the National Telecommunications and Information Administration of the Department of Commerce, the Corporation for Public Broadcasting, and commercial and public service broadcast agencies. This arrangement provides coordination and the free flow of information, without committing the States, and lets them set their priorities, policies, and program directions. All-day workshops on "Educational Applications of Telecommunications Technologies" were held for all States east and west of the Mississippi River in New Orleans and San Diego, and cosponsored by NTIA. The workshops provided insights on the technologies, such as the electronic blackboard, ITFS, video-disc, cable and satellite. The steps taken by NTIA to "bring the benefits of the national investment in satellite technology to the public sector" were assessed to determine ways to strengthening working relationships between grant recipients and the State adult education programs.

Developments were presented by State directors from New York, Virginia, South Carolina, West Virginia, New Jersey, American Samoa California, Hawaii, Missouri, and Arkansas. These reports revealed a high level of interest, and differences in the development stages of both hardware and software in each State program. For example, the State director from Wisconsin reported that staff training seminars were being telecast via satellite by the Professor of Adult Education, University of Wisconsin, while on sabbatical leave in London, England. New York State is seeking equipment and funding support for interconnecting a tricounty televised system operating daily from an adult learning center in Albany. Colorado is seeking assistance in developing the adult education component of the Governor's 5-year plan for the use of telecommunications in the State. Under a Department of Education grant, the San Diego State University is developing televised programs for older adults, produced by older adults.

The potential of using instructional television fixed service (ITFS) for instruction and staff development was explored with the State director in Virginia and the program director for KPBS–TV, San Diego. State directors and their staffs will secure training in telecommunications for participating in a national teleconference via satellite sponsored by the National Training and Development Service. The use of mobile TV systems in rural areas of Mississippi has been targeted by the Appalachian Community Service Network and can be extended to other areas.

Policy and program implications were synthesized in workshop recommendations for future meetings, and technical assistance needs for tapping potential resources were identified. Two task forces were formed to give leadership and direction to this significant development. First priority in 1981 will be given to the development of a national catalog of instructional materials for adults to be used on public radio and TV.

It is too early to fully assess the effects of the above program initiatives and administrative actions on older adults and other segments of the adult population. A major beginning is underway to effectively implement the 1978 amendments to the Adult Education Act. Reports from the States indicate between 1978 and 1979 there has been a 19,748 (16 percent) increase in older adults 65 years of age and older in the program. In 1980 incoming enrollment data from the States provide a basis for the projected age distribution of participants below.

TABLE 1

Age group	Estimate	Percentage
16 to 44	1, 488, 905	79
45 to 64	261, 961	14
65 and over	128, 612	7
Total	1, 879, 478	100.0

The estimated increase in enrollments of participants by age groups in 1980:

TABLE 2

Age group	Estimated enrollment	Estimated increase	Percentage increase
16 to 44	1, 488, 905	26, 326	2
45 to 64	261, 961	22, 727	10
65 and over	128, 612	24, 134	23
Total	1, 879, 478	73, 187	4

The actual and projected increases in enrollment of older adults are compatible with national trends and are expected to continue in fiscal year 1981 and throughout the decade of the 1980's.

These projections are supported by the increasing number of special projects directed to older adults by the States. Under section 310 of the Adult Education Act, many States are giving priority to older adults as a population group meriting special attention. Grant awards have been made to determine new and innovative approaches for expanding outreach and improving the effectiveness of instructional methods in meeting the educational needs of older adults.

Eight selected State-agency-funded projects focus on diverse activities designed to benefit older adults:

LOUISIANA—OLDER ADULT IMPROVEMENT: PREPARATION OR PEACE OFFICER ACCREDITATION

A pilot teaching program for deputies over 50 years of age to reactivate academic abilities.

FLORIDA—LITERACY EDUCATION FOR ADULTS WITH READING NEEDS (PROJECT LEARN)

A tutorial project to utilize the older citizens in Wakulla County to reach and teach reading skills to nonreading adults in the public school program.

INTERAGENCY LINKAGES FOR EDUCATION AND AGING

The project will conduct a Statewide assessment of personnel providing services to older persons, and older workers, and develop an inventory of education and training resources.

ALABAMA—COMMUNITY ADULT EDUCATION PROGRAM

The program is designed to provide several support services to the elderly in Adult Basic Education classes, including transportation and recreational activities.

WEST VIRGINIA—TELEVISED INSTRUCTIONAL READING PROGRAM FOR OLDER ADULTS

This project will develop recruitment and individualized reading tapes to be transmitted by TV as a supplement to regular adult education program, and improve outreach to older adults.

CONNECTICUT—JOB SKILLS WORKSHOPS FOR THE ELDERLY

To conduct 12 workshops annually and establish a "job bank" for the elderly, and measure the number who find employment during and after the workshops.

TEXAS—RECRUITMENT AND RETENTION OF OLDER ADULTS

To develop models of increasing recruitment and improving retention rates among older learners in adult education programs statewide.

NEW HAMPSHIRE—DOVER NEIGHBORHOOD OUTREACH PROGRAMS

A neighborhood outreach program serving senior citizens residing in low income and Federal housing areas.

VOCATIONAL EDUCATION PROGRAM

The Vocational Education Act, as amended by title II of Public Law 94–482, provides programs and services to meet the needs of displaced homemakers and other special groups, such as single heads of households, homemakers and part-time workers who wish to secure a full-time job, and women and men in jobs traditional for their sex who wish to secure employment in a nontraditional area. Each State must conduct a needs assessment to determine the needs of these special groups. Although the act makes no age distinction in serving these groups, older adults are eligible to participate in the programs and services offered both for these special groups and in the regular vocational education program. All States are required to serve these special groups; however, funding levels for such programs is left to the discretion of each State. Total Federal and State expenditures in fiscal year 1980 for vocational education programs serving displaced homemakers and other special groups were $2,432,778.

COMMUNITY EDUCATION PROGRAM

The community education program authorized by the title VIII of Public Law 95–561, the Education Amendments of 1978, provides grants to State and local education agencies and to nonprofit, public and private agencies in order to stimulate the development of community school centers which provide educational, cultural, recreational, and other related services in accordance with local interests, needs, and concerns. Additional awards are made to institutions of higher education to train persons who will plan and operate community education programs.

Federal and/or State grants made to local education agencies are for the purposes of paying the administrative costs of planning, establishing, expanding, and maintaining these community-oriented programs. None of the costs of the actual services, educational programs, or other activities is supported under this legislation.

In order for a local education agency or a nonprofit agency to receive a grant the applicant must propose to meet eight minimum elements which are considered to compose any community school. One of those minimum elements is the potential of the community education program to serve all age groups in the community, including the elderly. In the local educational agency category, 48 projects were funded in fiscal year 1977, 45 were funded in 1978, 37 were funded in 1979, and 25 were funded in 1980 at an average of $40,000 per project. The first year of funding nonprofit agencies was 1980 when 9 projects were awarded an average of $55,000 per project.

CAPTIONED FILMS AND TELEVISION

Under the Education of the Handicapped Act, part F (Public Law 91–230, as amended), films and television are captioned for the deaf. The program provides a free loan of service of captioned theatrical and education movies to groups of deaf individuals across the Nation. A considerable number of the people served by this program are over age 65. Of great importance is the extension of the film program to include captioned television. Captioned television programs may reach as many as 5 million hearing impaired individuals over the age of 65.

Public television captioning has taken two forms: "Open captions," which are visible to all viewers, and "closed captions" which are visible only on sets and stations with decoding devices. The open captioned rebroadcast of the ABC evening news which was begun in December 1973 is widely known and still is the only captioned news program.

In 1973, the Bureau of Education for the Handicapped (now known as the Office of Special Education) contracted with PBS to develop a closed captioning system. This system became operational in March, 1980. ABC and NBC are each providing 5 hours of programing, not including specials that are captioned from time to time. PBS is providing approximately 20 hours of programing per week. Decoders are available from Sears, Roebuck and Co. in two formats: an adapter that can be attached to any television set and a 19-inch color set with built in decoder. This system makes it possible for hearing impaired persons to have a wide variety of captioned television programs without interfering with the normal viewing habits of the general public.

The deaf and hard-of-hearing population is estimated at 13.4 million. A large percentage of this population is made up of older Americans whose hearing has deteriorated with age. These individuals are a prime audience for captioned television.

BASIC VOCATIONAL REHABILITATION SERVICES

Under the Rehabilitation Act of 1973 as amended (title I, part B, section 110 basic vocational rehabilitation services are provided by State rehabilitation agencies to assist handicapped individuals to prepare for and engage in gainful occupations. Federal regulations provide that no upper or lower age limit is established as an eligibility requirement for the program. It is estimated that in fiscal year 1980 about 3 percent of those individuals rehabilitated through the program were 65 years of age and older. Services provided include medical diagnosis, vocational evaluation, counseling, medical care, vocational training and employment placement, and followup.

NUMBER OF PEOPLE REHABILITATED

Fiscal year	All rehabilitants	45 years of age and over	65 years of age and over
1979	294,396	63,309	7,076
1980	[1] 275,764	[1] 59,900	[1] 7,200

BUDGET DATA

Basic State grants	45 years of age and over	65 years of age and over
1979	$190,213,515	$21,263,000
1980	[1] 190,514,900	[1] 23,000,000

[1] Estimated.

A cooperative agreement, currently in the proceess of being revised, has been developed between the Rehabilitation Services Administration and the Administration on Aging. The agreement will improve coordination between resources available under the basic vocational rehabilitation program and those available under provisions of the Older Americans Act of 1965, as amended. Coordination of the Rehabilitation Services Administration with the Social Security Administration has also resulted in the referral of older and disabled persons who have applied for social security disability insurance and supplemental security income benefits to State vocational rehabilitation.

SPECIAL PROJECTS SERVING THE OLDER BLIND POPULATION

Under the Rehabilitation Act of 1973 as amended (section 311 (a)(1)), special projects are funded to serve the older blind population. The consideration of age as a factor for receiving services is prohibited under these special projects.

During fiscal year 1980, the Rehabilitation Services Administration funded one new older blind project and continued five other special projects. These grant awards totaled $490,471. The projects address special problems of older blind people found in rural, urban, and inner-city areas; special problems of minority groups such as blacks and Hispanics; and special problems faced in employment settings such as home industries and second careers.

FISCAL YEAR 1980 SPECIAL PROJECTS SERVING THE OLDER BLIND

Grantee:	*Award*
Chicago Lighthouse for the Blind, 1850 West Roosevelt Road, Chicago, Ill. 60608	$101,800
New Hampshire Association for the Blind, 60 School Street, Concord, N.H. 03301	86,150
Vocations and Community Services for the Blind, 117 West 70 Street, New York, N.Y. 10023	54,053
Pennsylvania Association for the Blind, 1930 Chestnut Street, Philadelphia, Pa. 19103	71,703
Massachusetts Commission for the Blind, 110 Tremont Street, Boston, Mass. 02108	44,646
Vera Institute of Justice, 30 East 39th Street, New York, N.Y.	132,119

RESEARCH AND TRAINING CENTERS

Rehabilitation research and training centers are authorized under title II sections 202 and 204 of the Rehabilitation Act of 1973 (as amended by Public Law 95-602). In fiscal year 1980, the National Institute of Handicapped Research funded for the first time two research and training centers in the area of aging—one at the University of Pennsylvania and one at Rancho Los Amigos Hospital in conjunction with the Ethel Percy Andrus Gerontological Center and the University of Southern California Medical Center. The centers will address problems of the Nation's 23.5 million elderly persons, many of whom are handicapped.

The two centers share the same goals: creating and conducting a research program related to rehabilitation of the handicapped elderly, providing training in rehabilitation of the handicapped elderly, disseminating information on the rehabilitation of this group and assisting others in using research findings, and developing educational materials. The focus of activities undertaken to accomplish the goals differ, however, for the two centers.

The University of Pennsylvania's research program currently focuses on the physiological and neurophysiological effects of stroke, the impact of bladder incontinence in the elderly, the effects of group therapy of disabled elderly, and the psychological status of families caring for the impaired aged. In its first year of operation, the center s training program is concentrating on disseminating existing information on aging and resources available to respond to the needs of the impaired elderly.

The center at Rancho Los Amigos Hospital is focusing on the effect of multidisciplinary treatment for depression among the elderly, the support provided to professionals working with the handicapped elderly, and health assessment and treatment needs of handicapped elderly Mexican Americans. The training program currently targets on providing continuing education to aging and rehabilitation professionals, students, the elderly handicapped and their families, providing internships to students from the health professions, and developing educational training materials.

Fiscal year 1980 funding for the centers totals $400,000.

ITEM 5. DEPARTMENT OF ENERGY

FEBRUARY 10, 1981.

DEAR MR. CHAIRMAN: In response to the letter from the Senate Special Committee on Aging requesting an update of the Department of Energy's (DOE) activities in 1980 affecting older Americans, we are pleased to submit the following report. The wide range of DOE activities affecting the lives of older Americans during 1980 are organized into five categories: Policy initiatives; service delivery programs; information collection and dissemination activities; public participation activities; and research on the biological and physiological aging process.

Before detailing the activities in each of the above categories, an overview of DOE's efforts should be considered. The immediate and long-term objectives are the assurance of adequate, available, and reasonably priced energy supplies for American consumers. DOE remains sensitive to the impact of energy cost and supply on older Americans and low-income households whose resources are strained to meet their basic energy needs.

During 1980, DOE has been aware of the need to address policy and price impact issues on the older consumer and has continued to make efforts to be involved with national organizations and other Federal agencies who have been concerned with energy needs of older Americans. Those activities will be addressed in more detail below. Energy conservation, the development of renewable domestic fuels, utility regulatory reform, energy development impact assistance, and conservation incentives through tax credit are some of DOE's activities that have had significant implications for older Americans. The following will be a description of activities and programs in each of the aforementioned categories:

POLICY INITIATIVES

DOE has continued as a very high priority the implementation of the National Energy Act. It has supported and contributed to other major legislation that will have an effect on the lives of older Americans, such as the low-income energy assistance program (title III of the Windfall Profits Tax Act). It has continued to make strenuous effort to assure that the energy-related needs of older Americans have been equitably met. The following are examples of policy initiatives that have been taken to respond to the issues concerning other Americans.

Utility regulatory reform activities: DOE completed an indepth review of 20 lifeline rate programs to determine their impact on elderly and low-income families, other customers, and the utility companies; and issued a three-volume report, "Lifeline Electric Rates and Alternative Approaches to the Problems of Low-Income Ratepayers." The report recommended that lifeline rate hearings evaluate various promising nonrate policies along with lifeline proposals and thus, identify the most effective delivery mechanism for energy assistance to low-income households. (The report can be obtained from Economic Regulatory Administration, Washington, D.C.)

DOE provided funds under its innovative rates program to four States for 2-year projects to study: (a) The costs and benefits of lifeline-type rates to low-income consumers of electricity, (b) the kind of assistance programs currently available to this class of customers, and (c) whether a specific low-income rate is appropriate and justified. A fifth project, carried out by the Virginia State Corporation Commission was completed in September 1980. The completed report from Virginia, "An Evaluation of Lifeline Electric Rates," concludes that a "blanket" lifeline rate may not be an effective method of assisting low-income and/or elderly electric customers. Based on economic efficiency criteria, Virginia State Corporation Commission staff and their consultant agree that direct assistance is the preferred method of helping low-income customers. (Reasons for this conclusion and a brief summary of the project results are contained in the enclosed Virginia State Corporation Commission staff report.)

Energy assistance programs: DOE actively supported the administration's efforts to implement the energy crisis assistance program and the energy allowance program during the winter of 1979–80. These programs, administered by the Community Services Administration and the Department of Health and Human Services, respectively, provided $1.6 billion in assistance to low-income families. Much of this assistance went to the elderly: $400 million of the energy allowance program was specifically earmarked for recipients of supplemental security income program, who are predominantly elderly. During 1980, DOE was actively involved in securing passage of the Home Energy Assistance Act of 1980 (title III of the Windfall Profits Tax Act) and assisted Health and Human Services in implementing the provisions of this act during the winter of 1980–81. This program was the major followon to the energy crisis assistance program and is the formalization of a larger term program to assist low-income groups with a special emphasis on the elderly. Funding for the winter of 1980–81 is $1.8 billion.

Weatherization program: The elderly and the handicapped are given priority under this program, which provides grants for the installation of insulation, weather-stripping, storm windows, and other energy-saving measures. In response to some operational problems, key regulatory changes were made during 1980 which increased the number of eligible households and units weatherized.

Residential conservation service: During 1980, DOE approved State plans for the implementation of the residential conservation service program. This program, as originally authorized, required utilities to offer energy audits and to offer to arrange for the installation and financing of energy conservation measures on single-family dwellings. With the enactment of the Energy Security Act in 1980, two changes to this program have been made:

- Utilities are now permitted to directly finance energy conservation measures, therby allowing them to undertake lending programs for their customers.
- The benefits of the program have been extended to multifamily dwellings.

This program, while available to all customers of covered utilities, should be useful to the aged by providing objective information on energy conservation investments and the necessary financing for their installation.

New residential energy conservation initiatives: The Energy Security Act of 1980 authorized a Solar Energy and Conservation Bank. Under the provisions of the bank, subsidized financing (up to 50 percent) will be provided for energy conservation improvements. This program appears to benefit the elderly who have the highest rate of homeownership of any age group.

DOE is experimenting with a one-stop shop retrofit delivery system which would provide financing and quality control for conservation programs. This again could be helpful to the elderly by simplifying program delivery and assuring quality control.

Impact of energy prices and policies on socioeconomic groups: DOE continues to measure and analyze the impacts of energy policies and rising energy prices on various socioeconomic groups.

SERVICE DELIVERY PROGRAMS

Weatherization assistance program: DOE, in cooperation with the Community Services Administration and the Department of Labor, initiated an action plan to speed delivery services. The low-income elderly and handicapped receive priority under this program, which provides grants for the installation of insulation, weatherstripping, storm windows, and other energy-saving measures.

In the 1980, the weatherization assistance program awarded over $163,544,231 in grants to States and 24 Native American tribal organizations for the weatherization of homes of low-income persons. Reports from the inception of the program through October 1980, indicate that 487,541 low-income homes were weatherized and that the majority of those dwellings were occupied by the elderly. In fiscal year 1980 alone, 265,182 homes have been weatherized.

Residual conservation service: Scheduled for implementation by the States in early 1981, this program requires major utilities to offer energy audits, to offer to arrange for the financing of the purchase and installation of energy conservation measures and to permit repayment of the loans through monthly utility billings. The program also requires development of State-approved lists of suppliers and contractors and should be useful to the elderly as well as other members of the population.

Residential tax credits: The residential tax credits provide tax incentives to individuals for the installation of energy-conserving equipment and devices. Available through the 1985 tax year, the program provides for tax credits of 15 percent of the cost of equipment purchase and for instal'ation up to a maximum of $300. While the program is available to all taxpayers, it appears to be useful to the elderly, many of whom occupy older homes with less efficient heating equipment and insulation.

Institutional conservation program: Title III of the National Energy Conservation Policy Act provided for a matching grant program to support professional analyses of the energy conservation potential in public care facilities. The effect of this program is to identify for building operators ways to conserve energy and thus cut their operating costs. The program also hopes to influence the capital investment decisions of the institution's management.

During fiscal year 1980, the program made awards to 75 nursing homes. As of this writing, no reports have been received on the results of those awards.

Appliance efficiency program: During 1980, DOE continued its effort to develop minimum energy efficiency standards for 8 of the 13 products initially covered by this program. The eight products are furnaces, clothes dryers, refrigerators and refrigerators-freezers, freezers, central air-conditioners, room air-conditioners, water heaters, and kitchen ranges and ovens. The proposed standards are slated for initial promulgation in January and February 1981. While this program is of benefit to all purchasers of these appliances, it appears to be useful to the elderly whose limited incomes require purchase of the most cost-efficient products.

INFORMATION COLLECTION AND DISSEMINATION ACTIVITIES

The Energy Information Administration conducts analyses of the expenditure impact of changing energy prices and other energy policy issues of various population groups, including the elderly. These analyses are conducted using the "Microanalysis Transfers to Household/Comprehensive Human Resources Data System, MATH/CHRDS" computer model.

During 1980, the Energy Information Administration prepared a report containing information concerning expenditures for energy by the elderly. This report, prepared by the Office of Applied Analysis, contains estimates of expenditures for energy by fuel type for 1975 and 1985 for elderly and nonelderly households. The report, entitled "A Comparison of Energy Expenditures by Elder'y and Nonelderly Households—1975 and 1985" (GPO No. 061-003-00117-3), provides both regional and national level estimates.

In addition, the Energy Information Administration, through its Consumption Data System (CDS), collects and publishes comprehensive data on energy consumption, storage, cost by fuel type, and related housing unit characteristics (such as size, insulation, and major energy-consuming appliances) for the residential sector.

In 1980, Consumption Data System published the following information concerning the elderly:

Results about the elderly from Energy Information Administration's first nationwide survey of residential energy consumption were published in 1980. The 1978 national interim energy consumption survey collected data from individual households and actual billing data from the households' fuel suppliers for 1 year's period. The report, "Residential Energy Consumption Survey: Consumption and Expenditures, April 1978 through March 1979" (GPO No. 061-003-00131-9), provides national estimates of the cost and amount of electricity, natural gas, fuel oil and kerosene, and liquefied petroleum gas used by all households including those headed by the elderly.

Another national interim energy consumption survey report, "Residential Energy Consumption Survey: Conservation" (GPO No 061-003-00087-8), presents national estimates on insulation characteristics of housing units for which the household head is elderly (large apartment buildings are not included). The report also indicates the type of insulation and equipment covered by the energy tax credits that have been added by the elderly in 1977 and 1978.

These three reports can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

PUBLIC PARTICIPATION ACTIVITIES

In its continuing efforts to actively involve older Americans in policy formulation and decisionmaking process of the Department, the Consumer Affairs Advisory Committee has included representation for a major national organization of older persons. The National Retired Teachers Association/American Association of Retired Persons, is now represented on this advisory committee.

DOE was actively involved during 1980 in formation of, and has been represented on the "Ad Hoc Energy and Elderly Consortium." This organization is composed of over 60 organizations from the public sector, private nonprofit sector, and from the energy industry. This organization is the only one of its kind that brings together Federal agencies such as DOE, Community Services Administration, and Administration on Aging together with national aging organizations, and the private industry sector such as the American Gas Association, American Petroleum Institute, Edison Electric Institute, and others, to review and discuss solutions for the energy-related needs of the elderly.

Through participation in this group, DOE has exercised leadership in forming partnerships with a variety of organizations that have worked to meet the energy needs of the elderly.

DOE helped underwrite and actively participated in the 1980 Mini-White House Conference on Energy and the Elderly, entitled, "Energy Equity and Elderly for 1980's." This miniconference was jointly funded by several Federal agencies and conducted by National Retired Teachers Association and American Association of Retired Persons. DOE actively collaborated in conceptualizing and conducting this conference. The conference report which is expected to be issued in early 1981 will present a series of recommendations and policy options for energy and the elderly.

DOE is represented on the Intergovernmental Task Force for the 1981 White House Conference on Aging. This activity brought together several activities in DOE to address the policy issues formulated during 1980 miniconference on "Energy Equity and the Elderly."

DOE developed and published a comprehensive analysis and report on State utility commission termination of service policies. This report identified specific policies that were sensitive to vulnerable population groups like the elderly.

DOE prepared a thorough assessment and a series of options to redistribute oil company overcharge funds to low-income consumers and the elderly who would be in need of additional resources for fuel and utility costs during the winter. These funds were obtained by DOE in legal settlements.

During 1980, DOE began a major report on the impact of increasing energy costs on the moderate- and low-income households that will give attention to needs of the elderly.

RESEARCH ACTIVITIES

Although DOE does not sponsor an organized program of research on the aging process, two categories of studies related to biological aging were continued during 1980: (a) Studies not directly concerned with biological aging but that produce data on physiologic and pathologic changes occurring in aging human and animal populations, and (b) studies directly concerned with elucidating the biological basis of aging.

A complete description of these research activities is enclosed.

We are pleased to contribute to your annual review of Federal actions and programs related to aging.

Sincerely,

JAMES B. EDWARDS.

Enclosures.

Enclosure 1

SUMMARY OF AN EVALUATION OF LIFELINE ELECTRIC RATES BY VIRGINIA STATE CORPORATION COMMISSION

In order to assess the findings and recommendations resulting from any study, a careful evaluation of the methodology and scope of the project must be made. Through careful planning of this project, every effort was made to insure the applicability of the results; however, time and financial constraints prevent any study from being universally applicable. Thus, in order to properly evaluate the recommendations and findings contained in the consultant's report, it is appropriate to note the limitations of the project. Section I discusses the scope of the demographic survey and section II presents staff comments on the analysis of alternative assistance plans.

I. THE DEMOGRAPHIC SURVEY

As documented in volume I of the consultant's report, a telephone survey was conducted. Because of time and financial constraints, the consultant and the SCC concluded that a telephone survey was the preferred method. This approach excludes from consideration those individuals without telephones or with unlisted numbers. According to telephone company statistics it was expected that approximately 5 percent of households are without telephones while 12 percent have unpublished numbers. However, in actually obtaining the telephone numbers for the randomly selected master sample, the consultant found that in the VEPCO service territory 22 percent had no number listed and 10 percent had unpublished numbers. For the APCO master sample, 23 percent had no number listed while 5 percent had unpublished numbers. Although these percentages are noted in the consultant's report, it should be pointed out that checks performed on the sample data revealed that there was *no measurable bias* of the sample as a result of unlisted and unpublished telephone numbers. A comparison of the sample data to secondary data and to master sample data revealed that there was no perceived effect on the critical variables; average household size, income, and electricity consumption.

The method chosen for the selection of the master sample by the utilities (see volume I) eliminated from consideration master metered households as well as households with less than 12 months of billing history at that address. Further, the survey did not cover the entire State, only the APCO and VEPCO service territories were included. It should be noted, however, that APCO's and VEPCO's residential electric customer accounts comprise approximately 80 percent of all such accounts in the State of Virginia.

II. THE ANALYSIS OF LIFELINE ELECTRIC RATES

The consultant developed an algorithm used to quantify the impact of hypothetical lifeline rates on various customer groups. This algorithm is presently being installed at the SCC and will be used by the staff to evaluate specific rate schedules proposed by the legislature and the utilities. The algorithm coupled with the data base obtained from the survey represent the major contribution of the project in that it allows the staff to quantify the impact of specific lifeline rate proposals.

As part of their analysis, the consultants estimated the tax burden per income level necessary to raise $100 of additional revenue. These estimates are intended to be illustrative of the general level of the tax burden for comparison to lifeline rate burdens. The tax burden estimates were based in part on a study of tax levels in Richmond, Va., and should not be interpreted to precisely measure the burden for the entire State.

The hypothetical lifeline rates examined in the study (see volume II) provide general information on the impact of changes in the size of the lifeline block, the lifeline rate, and target population. This analysis shows that a "blanket" lifeline rate may not be an effective method of assisting low income and/or elderly electric customers. Based on economic efficiency criteria, the staff agrees with the consultants' conclusion that:

"The comparison of lifeline rates to alternative assistance programs shows that direct assistance is the preferred method of helping low-income customers for several reasons. With a direct assistance program:

—Benefits can be directed specifically toward persons in need of assistance.
—Greater amounts of individual assistance can be provided than through lifeline rates.
—A significantly smaller dollar transfer is needed to yield an equal level of benefits. Conversely, greater per capita benefits could be realized for the same gross level of transfers.
—The taxes necessary to support a direct assistance program are more progressive or directly related to income.
—Cost-based electricity prices increase economic efficiency and social welfare by giving the proper signals to customers concerning the costs to society of additional electricity consumption."

The SCC staff is in agreement with the general methodology employed by the consultant to analyze the assistance programs. The consultant's analysis presented in volume II provides background information which is used in the design and selection of assistance programs. However, before recommending or rejecting a particular method of assistance, the costs and benefits of the *specific* program should be analyzed. In addition, other issues must be welfare questions, and administrative considerations. Once specific lifeline proposals are presented to the Commission, either with respect to a lifeline hearing or in some other context, then the methodology will be used to conduct an economic analysis of such proposals.

Enclosure 2

REGIONAL ACTIVITIES RELATED TO THE AGED DURING 1980

REGION I

Senior citizens are among the groups contacted to give testimony at public hearings on the Department of Energy (DOE) policy and regulations. Such an effort last year involved the gasoline rationing hearing, as well as the proposed changes to the weatherization regulations which now provide greater flexibility, with the end result being that more homes are being weatherized. During 1980, in the six New England States, approximately 12,910 senior citizens were assisted through the weatherization program.

REGION II

Consumer affairs officer moderated the energy panel at a conference of the hispanic elderly held at Fordham University in March 1980. An overview of energy programs benefiting the elderly was provided; Spanish language literature on energy matters was distributed; and a list of persons to contact for various energy related matters was developed specifically for this conference.

Consumer affairs officer continued to represent DOE on the Federal Regional Council's Subcommittee on Aging. Membership on this subcommittee has enabled us to inform, on a timely basis, the Administration on Aging and other relevant Federal and State agencies of energy programs and other developments significant to the elderly population.

Nine subgrantees of the urban and communities program of New Jersey's Energy Extension Service are delivering services to the elderly. Among the services provided are energy audits, one-on-one technical assistance on low cost/no cost energy conservation measures, and workshops that tell senior citizens how to avoid and what to do in the event of hypothermia, shutoffs, and difficulties with fuel merchants. Many of the workshops are held at senior citizen centers and other places where the elderly normally gather.

From January 1 through November 30, 1,728 elderly persons in New Jersey were assisted by the weatherization assistance program. During the same period of time, 4,765 elderly persons in New York were assisted under the weatherization assistance program.

REGION III

During the fiscal year 1980, there were 20,395 elderly occupants in the 35,201 homes weatherized under a program funded at $22,072,620.

In addition, the State energy offices are encouraging public care institutions to take advantage of the grants program for schools, hospitals, local government, and public care institutions which provides 50–50 matching funds to conduct energy audits, technical assistance reviews, and to implement specific energy conservation measures in these facilities.

REGION IV

Region IV developed two publications which were found to have significant impact in terms of their meeting information needs in the area of conservation for senior citizens. The first publication was written by the consumer affairs officer who geared the publication toward meeting the needs of the elderly on low and/or fixed incomes. The brochure is entitled, "How to Keep Warm and Cut Your Fuel Bill," and has proved to be an excellent booklet which is both easy to understand and whose energy-saving ideas are simple to implement. 150,000 copies of the booklet have been distributed across the region to public and private organizations serving the needs of the elderly population. Requests for this publication have been received from across the Nation. The same energy- and money-saving ideas offered in the booklet "Tips for Energy Savers" was made available through region IV efforts on a 33 rpm flexible disk in both English and Spanish. The disk was specifically developed as an aid to the elderly, blind, and handicapped. The material was endorsed by the President's Committee on the Employment of the Handicapped.

Hot weather energy conservation and safety is a major concern to region IV due to its geographic location. The need for increased response to this topic was dramatized this summer as temperatures rose to record heights. The number of people who died from heat-related causes increased greatly and many people, especially the elderly, suffered from the heat simply because they were unaware of alternate methods of cooling. To assist in remedying this problem, region IV is currently working to develop a publication focusing on energy conservation during hot weather months. This project will be funded through DOE, Office of Consumer Affairs.

During 1980, $22,410,200 was awarded to States for weatherization assistance in region IV. As of the third quarter of 1980, a total of 31,316 homes were weatherized and 28,900 of these homes were occupied by elderly residents. The appropriate technology program received 2,111 applications in 1980 and approximately 18 percent of those proposals were from the elderly.

The Georgia energy assistance program in conjunction with the Department of Human Resources and State Government Economic Opportunity Office asked for our assistance in providing conservation information to recipients of program funds. 150,000 publications, including seven different energy conservation pamphlets were distributed to local agencies. Sixty-one percent of the total households served by the program consisted of elderly residents.

REGION V

The weatherization program in region V is the largest in the country. For example, of approximately 30,000 homes weatherized across the country in the month of September 1980, more than 26 percent (over 8,100) were done in the six States in region V. In 1980, 27.7 percent of those receiving assistance under this program in our region were the elderly—50,770 out of 183,518. By regulation, this program is designed to help low-income people, particularly the elderly and handicapped. It is this sector of the population which benefits the most from weatherization of their homes, as 30 to 40 percent of their income goes to pay for energy.

Two funding cycles have now been completed under the DOE program granting energy conservation funds for schools, hospitals, local government buildings, and public care facilities: 20 percent of the region V grants under this program were to facilities which aid the elderly; 400 out of 2,000 grants were to hospitals and public care facilities. The benefit to the elderly should be both direct and indirect, as the energy audits, technical audits, and installation of energy conservation measures funded by the program lead to improved comfort in living environments and reduced operating expenses for these facilities.

A program of the Wisconsin Energy Extension Service, run by the University of Wisconsin Extension, Milwaukee, is housed in the inner city of Milwaukee. It targets moderate-income residents, providing information on conservation and solar energy, workshops, and energy audits. A significant number of the clients served are elderly.

The appropriate technology program encourages individuals and small businesses, who may have ideas for energy-saving devices or systems, to apply for grants to assist them in developing those ideas which may end up in the open marketplace. In 1980, two retirees received one of these grants (46 were given in all), and in 1979 3 out of 62 were grants to retirees.

In addition, DOE region V cosponsors (with the Use Energy Wisely Committee of Chicago) an annual Energy and Home Improvement Fair, with exhibits, workshops, and 300 to 350 booths. Among the 100,000 attending in each of the 2 years it has been held, are elderly residents of the greater Chicago area.

REGION VI

The weatherization program directly responds to the needs of senior citizens within region VI. During the first 9 months of 1980, homes with 14,186 elderly or handicapped persons in residence were weatherized against winter temperatures. During the heat wave of the summer of 1980, funds were made available for attic fans. An example of the need for hot weather measures is indicated by the installation of 771 attic fans and the repair of 22 cooling units in about 793 homes in Oklahoma for about $165,400.

Dialog has begun with the Southwest Society on Aging to determine possible means to alert the public and particularly the elderly concerning the hazards of extreme ambient temperatures which may result in hypothermia or hyperthermia.

A total of $1,146,948 was provided to the five States in region VI during 1980 to conduct preliminary energy audits and energy audits as part of the institutional buildings grant program. Through June 30, 1980, a total of 1,548 hospitals and nursing homes had received assistance to conduct preliminary energy audits. In addition, region VI awarded technical assistance and energy conservation measures grants totaling $3,788,562 in fiscal year 1980 to hospitals and public care institutions. These funds indirectly assist senior citizens, as well as all citizens, by curbing the rising energy costs of health care operations.

During 1980, region VI awarded two grants under the appropriate technology small grants program (a total of $28,100) which assisted the elderly.

Senior citizens have been given exemptions under the DOE emergency building temperature restrictions program. Senior citizen nutrition and recreation centers are permitted to raise the dry bulb temperature to 70°F (rather than 65°F) during the period of time senior activities are conducted.

Three States in region VI under the energy extension service (EES) program have programs which are aimed at providing assistance to the elderly. The State of Arkansas has implemented a senior Arkansas value energy program to assist elderly Arkansans cope with the high cost of energy. To date this program has been responsible for performing 320 home energy audits of elderly persons' homes. In New Mexico, EES funds are being used for a public information program which includes a toll-free hotline. It is estimated that about 690 senior citizens have been assisted to date in 1980. The State of Oklahoma has also established an energy information center where elderly persons can obtain advice and information on energy conservation.

The regional energy information center (REIC) provides information and referral services on DOE programs and activities as well as other energy-related subjects. Up to 500 information requests are handled per month by the REIC. Senior citizens who need assistance with energy conservation information or in finding sources of financial assistance are among those calling the REIC. Bulk supplies of pamphlets are provided to groups such as the Southwest Society on Aging. The REIC maintains mailing lists for the use of the regional representative and other program areas containing selected categories such as individuals representing the American Association of Retired Persons and the National Retired Teachers Association.

The regional bimonthly Consumer News Brief newsletter is sent to many seniors and their representatives as part of the developing networking system which includes other Federal agencies, State, and local groups.

REGION VII

Region VII recently sponsored an energy extension service conference in Clinton, Mo., where attendees heard from some enthusiastic solar consumers. This sounds routine except that these solar advocates were in their seventies and eighties. They were recipients of solar systems in the nine-county area served by the West Central Missouri Rural Development Corporation, directed by Charles Braithwait. Starting 3 years ago with an office of aging grant and continuing through the solar utilization/economic development and employment (SUEDE) project, this agency has installed 135 systems on houses of aged and low-income families. The houses had previously been weatherized under the DOE weatherization assistance program.

These solar consumers give a new perspective on what was described at the conference as the "reality" of low-cost solar. One woman in her eighties, when asked how she knew the solar system had saved her fuel, pointed to her yard and said, "If it wasn't for solar, that wood that I cut myself would now be gone." Benefits were often described in terms of warmth rather than just energy savings suggesting that high fuel costs had previously prevented the people from maintaining adequate temperatures in their homes. The fuel saved can also be used for other purposes as illustrated by the woman who used surplus propane left after a solar-assisted winter to can food for her whole family. It is clear that the benefits need to be measured in terms other than just utility bill reduction or simple payback.

REGION IX

The most direct response to senior citizens has been the weatherization program which provides insulation and other improvements to low-income homes to protect them from winter cold or the searing heat of the Arizona and Nevada desert.

A total of 17,552 homes were weatherized in region IX in 1980. The total includes Arizona, 2,467; California, 12,900; Navajo Nation, 530; and Nevada, 1,655. The program gives preference to senior citizens.

REGION X

The most direct assistance program to the elderly has been the weatherization program. In fiscal year 1980, region X provided approximately $9 million through this program to region X States (Alaska, Idaho, Oregon, and Washington) with production doubling over the previous fiscal year. In addition to the four State grants and four Indian tribe grants, this region has 70 local delivery subgrantees. The program gives preference to low income and the elderly.

Region X boasts one of the most successful regional appropriate technology programs. Of the 272 project grant awards, approximately 20 were awarded to senior citizens.

The energy extension service has expanded from the Washington State pilot EES program to now include all four States in the region. The extension service, oriented to local community needs, offers workshops and classes which draw many elderly citizens interested in home energy efficiency. In the States of Washington and Oregon, a master conservation program provides participants with 50 hours of indepth training in energy conservation and renewable fuels use in exchange for 80 hours of volunteer public service to the community. This program has drawn particular interest from the retired community.

The institutional building grants program provided approximately $5 million during cycle II for technical assistance grants and energy conservation measure grants. Grants to nursing homes and hospitals indirectly assist senior citizen users of these public institutions by curbing rising energy costs.

Senior citizens turned out during public hearings on the standby gasoline rationing plan and the standby Federal emergency energy conservation plan which both had a direct effect on recreational vehicles. Region X participation on the latter hearing was instrumental in deletion of the personal rulemaking measure on recreational watercraft restrictions.

Senior citizens continue to be a large portion of the many visitors and callers to the public affairs office seeking general and specific energy information. The office assists them by answering questions directly, mailing out energy conservation pamphlets, or by referring citizens, in the area of crisis intervention, to other appropriate Federal and State agencies.

Speech requests continue to come from senior citizens groups such as the Civilian Conservation Corps Alumni.

Enclosure 3

RESEARCH RELATED TO BIOLOGICAL AGING

As in previous years, the Office of Health and Environmental Research (OHER) has administered a major program of research aimed at identifying and characterizing health impacts of the energy-producing technologies. In assessing energy-related health impacts, it is particularly important to determine long-term and late-appearing health effects induced by chronic exposures to low levels of hazardous chemical or physical agents. Since health effects induced by chronic low-level exposures to toxic agents typically develop progressively over the entire lifespan or a significant fraction thereof, it is essential that such effects be clearly differentiated from functional decrements, morbidity patterns, and mortality that occur as a result of the aging process. To make a statistically valid differentiation between induced health effects and spontaneously occurring aging effects, detailed information on pathophysiologic changes occurring throughout the lifespan must be collected for both exposed and unexposed (control) populations of adequate size. Pathophysiologic data are collected from human populations whenever possible but primarily from controlled studies of animal populations. Studies conducted in this manner inevitably generate data describing age-related changes that occur in unexposed populations and in populations exposed to specific toxicants. Such data not only help to characterize the aging process but also define how sensitivity to hazardous agents may change with age. Given the importance of the biological aging in the study of late-appearing health effects, additional studies are conducted in order to obtain a better understanding of the aging process itself. Thus, although the Department of Energy does not sponsor an organized program of research on the aging process, two categories of studies related to biological aging were continued during 1980: (a) Studies not directly concerned with biological aging but that produce data on physiologic and pathologic changes occurring in aging human and animal populations, and (b) studies directly concerned with elucidating the biological basis of aging.

As in the past, lifetime studies of human and animal populations constitute the major effort in the ongoing program of research related to biological aging. Because of an extensive and long-term involvement in lifetime animal studies, several Department of Energy laboratories are contributing information to the laboratory animal bank that is being developed by the Battelle Columbus Laboratories under support from the National Library of Medicine and other Federal health agencies. The Department of Energy laboratories are providing data on life histories, pathology, hematology, and clinical chemistry obtained from control (unexposed) animals, both long-lived and short-lived, used in long-term studies. Five research scientists actively involved in lifetime animal studies sponsored by the Department continue to participate in the work of the National Academy of Sciences' Committee on Animal Models for Research on Aging. This committee was established in September 1977, to evaluate small vertebrates as animal models for research on aging.

As in previous years, research directly concerned with the aging process was conducted on a limited scale at several of the Department's contractor facilities. Work at the Argonne facility focuses principally on the evolutionary-comparative paradigm of aging and longevity in which genetic considerations play a prominent role. George A. Sacher of the Argonne staff has recently served 1 year as president of the Gerontological Society. The Oak Ridge program is oriented toward molecular and cellular studies including research on the error theory of aging. This program is conducted jointly with the University of Tennessee Graduate School of Biomedical Sciences and is partly supported by a training grant from the National Institute on Aging.

Summarized below is research on or related to aging that the Department sponsored in 1980.

LONG-TERM STUDIES OF HUMAN POPULATIONS

These studies provide valuable data on health effects and life-shortening in human populations exposed to hazardous chemical and physical agents associated with the energy technologies. Additional information on lifespan and aging in human populations is also collected. Since long-term studies of human populations are costly, time-consuming, the complex, they are initiated on a highly selective basis.

The Radiation Effects Research Foundation (RERF), which is sponsored jointly by the Governments of the United States and Japan, continued work on a large-scale lifetime followup of survivors of atomic bombings that occurred in Hiroshima and Nagasaki in 1945. Over 100,000 persons are under observation in this study. Detailed clinical and laboratory studies as well as the collection of mortality and autopsy data are performed on both irradiated and control populations in order to identify diseases that have contributed to elevated morbidity and life-shortening among survivors. An important feature of the RERF program is the acquisition of valuable quantitative data on dose-response relationships. Useful data on genetic effects are also being collected. From time to time studies specifically concerned with age-related changes are conducted. Based on extensive data, it was recently reported that the "effects of ionizing radiation on mortality are specific and focal, and principally carcinogenic."

After being accidentally exposed in 1954 to radioactive fallout released during the atmospheric testing of a thermonuclear device, a group of some 200 inhabitants of the Marshall Islands has been followed clinically, along with unexposed controls, by medical specialists at the Brookhaven National Laboratory. The clinical followup has continued on a semiannual basis. Thyroid pathology, which has generally responded well to therapy or surgery, has been prevalent in individuals heavily exposed to radioiodine. Near completion is a study to determine the feasibility of providing birth to grave medical care for segments of possibly the entire population (±20,000) of the Marshall Islands.

There is a study going on at Wadsworth VAH, Los Angeles, which is producing information about immunologic changes as related to aging and the effects of radiation on immunologic reactions.

Nearly 2,000 persons exposed to radium occupationally or for medical reasons have been studied at the Center for Human Radiobiology, Argonne National Laboratory. Many individuals in the study receive medical and radiologic (dosimetric) examinations at the Center. Autopsy data are obtained when possible. Current work emphasizes the study of persons with relatively low body burdens of radium. Valuable data on tumor induction by bone-seeking, alpha-emitting radionuclides such as radium-226 are being generated in this study. Of particular importance are quantitative dose-responsive data for tumorigenesis. The Center recently initiated an epidemiologic study of a large worker population occupationally exposed to thorium (an alpha-emitting radioelement) by inhalation during the period from about 1935 to 1974. This study utilizes vital statistics, employment histories, and records from the Social Security Administration to evaluate health effects of internally deposited thorium. Medical and radiologic examinations are being conducted on 100 randomly selected workers. Data on both morbidity and mortality are being collected. The Center is also conducting a followup study in a small group of exposed humans to evaluate late-appearing health effects of plutonium.

At the Los Alamos Scientific Laboratory, an epidemiologic study of plutonium workers, past and present, at six Department of Energy facilities is in progress. This study involves a lifetime surveillance of worker health and causes of death. An estimated 15,000 to 20,000 workers will be followed in the study of mortality data and at least one-third of these will also be studied further by collecting detailed morbidity and personal-history data periodically via questionnaires. Data on internal dosimetry are routinely collected in order to study dose-response relationships. Autopsy data are obtained through the U.S. Transuranium Registry (see below). Valid conclusions are not yet possible but so far there is no excess mortality due to any cause in 224 males with the highest plutonium exposures; the possibly higher than normal incidence of cancer of the lymphatic and blood systems is no longer occurring; the higher than normal incidence of digestive tract cancers in both males and females is more likely due to cultural and socioeconomic factors; and, 26 males exposed to plutonium mostly by inhalation under extraordinarily crude conditions during World War II yield no evidence yet that adverse health effects exist 32 years after exposure.

A population of some 170,000 past and present contractor employees at Department of Energy production and laboratory facilities is being analyzed in an epidemiologic study designed to assess health effects produced by long-term exposure to low levels of ionizing radiation. Worker populations at the Hanford (Washington) and the Oak Ridge (Tennessee) plants plus a smaller group of contractor employees at the Mound Laboratory (Miamisburg, Ohio) are the subjects of the study, which is directed by the staff at the Oak Ridge Associated Universities (ORAU) with assistance in data collection and processing from teams at each of the facilities that house the workers' records. The study involves the statistical analysis of work records, medical records, and vital statistics (including mortality data and causes of death). Radiation dosimetry as well as exposures to other toxic agents in the work environment are carefully evaluated.

The U.S. Transuranium Registry, which is operated by the Hanford Environmental Health Foundation, collects occupational data (work, medical, and radiation exposure histories) as well as information on mortality and causes of death in worker populations occupationally exposed to plutonium or other transuranium radioelements. Detailed autopsy data are obtained on workers registered with the Foundation at the time of death. Every effort is made to obtain good dosimetric data on all registrants. At the present time, some 14,500 workers from 10 facilities are registered with the Foundation, and 73 autopsies have been performed. The autopsy data are made available for use in ongoing epidemiologic studies such as the ORAU study of radiation workers and the Los Alamos study of plutonium workers. A similar registry of uranium workers was started last year.

A lifetime study of human populations occupationally exposed to hazardous agents associated with nonnuclear energy technologies has been initiated. It is an epidemiologic study of workers at the Paraho oil-shale retorting plant located at Anvil Points, Colo. In this case, a small population of about 100 workers exposed to oil-shale dust and fugitive emissions from the retorting process is being studied to identify possible work-related health effects. The study involves an occupational survey (medical records), industrial hygiene survey (inplant monitoring of fugitive emissions), and periodic physical examination of workers.

LIFETIME STUDIES IN SHORT-LIVED MAMMALS

Although data from exposed human populations are indispensable in the assessment of health impacts associated with any hazardous agent, limitations inherent in human studies make it mandatory to acquire a substantial body of quantitative data from carefully controlled lifetime studies of animal populations. Reliable data from animal surrogates significantly enhance predictive capabilities. For purposes of comparison and a better understanding of variables affecting response patterns, data from both short-lived and long-lived mammals are needed.

Small rodents with lifespans of 2 to 3 years (rats, mice, hamsters) provide lifetime data in a minimum of time and at low cost. Because of these advantages, rodent populations have been extensively used in large-scale studies of late somatic and genetic effects induced by low doses of ionizing radiation. For example, at the Argonne National Laboratory and the Oak Ridge National Laboratory combined, more than 50,000 mice have been exposed to various doses of externally applied ionizing radiation delivered in different daily increments in order to characterize radiation-induced diseases and abnormalities that reduce the lifespan under various exposure regimes. These studies, in which both gamma and neutron radiations have been employed, continue to yield valuable information on the importance of dose rate and radiation quality as variables affecting mammalian responses to radiation stress. In addition, the careful study of control (unexposed) populations is providing valuable data on lifespan, morbidity patterns, and causes of death in unstressed animals. Additional lifetime studies of tumorigenesis and other late-appearing somatic effects of ionizing radiation in rodent populations have been carried out at the Brookhaven National Laboratory, the Lawrence Berkeley Laboratory, the Los Alamos Scientific Laboratory, the Battelle-Pacific Northwest Laboratories, the University of Utah, and the Lovelace Inhalation Toxicology Research Institute. These studies have included work with various types of ionizing radiation delivered to the animal body from external radiation sources and from internally deposited radionuclides. Approximately 30,000 rodents are currently under observation in lifetime studies at the above-mentioned laboratories. Included in the ongoing effort are studies involving external sources (neutrons, gamma radiation, and heavy ionizing particles), actinide isotopes that are present in nuclear fuels (plutonium-239, uranium-232, uranium-233, and others), radium isotopes, and products of nuclear fission (including tritium and krypton-85).

Rodent populations are also utilized in lifetime studies of health effects associated with exposures to energy-related chemical agents. In view of the large number of potentially hazardous materials requiring toxicological evaluation, such studies are conducted as part of a systematic multitiered screening and testing program. The number of ongoing lifetime studies has been increasing as short-term toxicological studies have continued to identify additional requirements for long-term testing. These studies are now producing data related to chronic disorders including cancer.

The bulk of the ongoing lifetime studies of chemical agents addresses potential health impacts of present-day and advanced fossil-fuel technologies. Two studies with a genetic focus are defining variables that influence tumor induction by polynuclear aromatic hydrocarbons that are present in emissions and effluents from many fossil-fuel operations. One is a study at the Brookhaven National Laboratory in which the induction of mammary tumors in the rat is under investigation. In the other generic study, a better understanding of processes involved in the multistage induction of rodent skin tumors is being gained. A recently concluded lifetime study was performed by investigators at the Pacific Northwest Laboratories to evaluate chronic diseases of the respiratory tract that might be caused by the inhalation of coal dust, diesel-engine exhaust, or combinations of the two. The latter study helped to define the carcinogenic and other health risks that exist in coal mines located deep underground.

Four ongoing studies are assessing health risks of coal-combustion technologies. Research at the University of California, Davis, is defining health effects of powerplant fly ash, alone and in combination with sulfur-containing emissions (sulfur dioxide or sulfates), using rats subjected to long-term exposures by inhalation. The major objective of this study is to determine functional and morphologic consequences of damage to the respiratory tract. At the Lovelace Inhalation Toxicology Research Institute, lifetime studies of rodents chronically exposed to emissions from conventional and fluidized-bed combustion facilities are in progress. Initial studies are concerned with particulate emissions (fly ash). Biological end points being assessed are lifespan shortening, functional disorders, and structural changes, including carcinogenesis. Two projects at the Pacific Northwest Laboratories are devoted to the study of the chronic toxicity of metals and metal oxides present in emissions and effluents from coal-combustion facilities. In these studies, rodents are exposed by ingestion and by inhalation. Special emphasis is placed on evaluating iron-deficient and newborn animals as subpopulations particularly sensitive to toxic metals. Ongoing work is evaluating aspects of cadmium toxicity.

A number of lifetime health-effects studies are conducted in connection with technologies concerned with the conversion of coal to secondary fuels and the extraction of oil from oil shale. Studies are underway to assess the cancer incidence and lifespan reduction caused by exposure to polynuclear aromatic hydrocarbons produced or released as a consequence of coal gasification and coal liquefaction. Argonne National Laboratory conducts a program which emphasizes research on the role of cancer-promoting agents in the enhancement of tumor yield and reduction of the latent period for malignant tumor production in skin, lung, and liver. At the Oak Ridge National Laboratory, lifetime animal studies are evaluating on a comparative basis skin, lung, and nonspecific cancer caused by various classes of compounds found in coal liquefaction products. A related project has begun to assess the chronic toxicity of various classes of chemical agents found in effluents and waste products from coal liquefaction operations. Lifetime studies in rats and hamsters now in progress at the University of Connecticut, Farmington, are defining chronic toxicity and carcinogenic risks associated with the ingestion and inhalation of nickel-containing materials present in waste streams of coal gasification facilities. Health risks associated with the solvent refining of coal to a solid fuel (SRC I product) and to a liquid fuel (SRC II product) are being defined at the Pacific Northwest Laboratories, where long-term studies of rodents chronically exposed by inhalation or dermal application to components of process streams and fugitive emissions are in progress. Also in progress at the Los Alamos National Laboratory is a project designed to assess chronic pulmonary toxicity of raw and spent oil shale and to define the pulmonary carcinogenitcity of crude shale-oil fractions.

Additional lifetime studies involving short-lived animals are providing increased knowledge regarding the inhalation toxicity of asbestos-containing insulating materials and of aerosols containing strong mineral acids of the type present in effluents and emissions from some energy-producing operations. These studies are conducted at the Pacific Northwest Laboratories and the New England Deaconess Hospital, respectively. In both cases, emphasis is directed toward the study of tumor induction. In the asbestos study, tumorigenesis after oral intake or intraperitoneal administration of the toxic agent is also under evaluation.

LIFETIME STUDIES WITH LONG-LIVED MAMMALS

From the point of view of lifespan and certain of the organ systems of particular interest, long-lived mammalian species represent better human surrogates than do their short-lived counterparts. This being the case, it is desirable to obtain quantitative data on responses of long-lived species to hazardous agents of concern. The beagle dog, with a life expectancy about one-fifth that of man, has served for more than 20 years as the long-lived mammal used in lifetime radiation-effects studies sponsored by the Department of Energy. Data from studies with beagles significantly facilitate attempts to interrelate data on animal responses with human response patterns. At the Argonne National Laboratory, the University of Utah, the University of California, Davis, the Lovelace Inhalation Toxicology Research Institute, and the Pacific Northwest Laboratories, more than 5,000 beagles have lived out their lives under careful experimental observations. In lifetime studies at these research centers, periodic clinical examinations and laboratory analyses are performed on all populations, exposed and control, and complete data on gross pathology and histopathology are collected at autopsy. Accumulated data contain a wealth of information on lifespan, age-related changes, morbidity, mortality, and causes of death in normal animals, as well as alterations in these characteristics that are induced by superimposed radiation stress. Approximately 3,000 beagles are currently under scrutiny in lifetime studies of late-appearing radiation effects. Included are studies of external radiation (gamma radiation) and internally deposited radionuclides of various types administered by inhalation, ingestion, or injection. All ongoing studies involve careful dosimetric measurements and the acquisition of dose-response data.

Because of their cost and the time required for completion, lifetime studies of beagle populations are initiated on a highly selective basis. No energy-related agent other than ionizing radiation has yet been evaluated in the beagle. It is anticipated that limited studies of other agents will be undertaken in the future as needs for such efforts are identified by shorter term testing in other systems.

RESEARCH MORE DIRECTLY CONCERNED WITH AGING

Several foci of interest within the Department of Energy laboratory system sustain a low level of research directly related to the aging process.

Ongoing studies at the Argonne National Laboratory are primarily concerned with developing an evolutionary-comparative paradigm of aging and longevity. This effort seeks to explain differences in lifespan of animal species on the basis of the natural selection of genetically determined traits. The Argonne investigators favor the view that longevity in mammalian species has evolved from a selection of traits conferring on individuals a lifespan and vigor that results in something approaching an optimum of growth, development, and reproduction for a particular ecological niche.

Over the years, extensive work on molecular, cellular, and physiologic aspects of biological aging have been conducted at several national laboratories. For example, Oak Ridge investigators have completed a substantial number of studies that have helped define age-related changes in the immune system of irradiated and unexposed rodent populations. The chief focus, however, of ongoing research at Oak Ridge is directed toward molecular and cellular aspects of aging.

Recent studies show that certain transfer RNA molecules, essential components of the cell's protein synthesizing machinery, change with age. This may explain earlier findings with hemoglobin that the fidelity of the synthesis of hemoglobin declined with age. Work continues on the multispecies comparative study of correlations that may exist between longevity of organisms and cellular capacity for the repair of damage in DNA molecules that encode genetic information. Studies of guinea pigs at the University of California exposed to radioiodine shows that the radiosensitivity of the thyroid gland of the animals changes with age. This study points out the need to be flexible in assigning risks for exposure to radioiodine and in applying radioiodine therapeutically.

TRENDS AND PROSPECTS

Given the need to assess long-term and late-appearing effects of hazardous agents associated with energy-producing technologies, lifetime studies of animal and human populations will continue. It is evident, in fact, that additional lifetime studies of chemical agents will be needed in the future. Accordingly, more data describing age-related changes should be forthcoming, and a modest program of research on the aging process itself is expected to continue.

SUMMARY OF RESEARCH SUPPORT

Table I provides a summary of Department of Energy support of research related to aging for fiscal year 1980.

TABLE I.—RESEARCH RELATED TO AGING SPONSORED IN FISCAL YEAR 1980 BY THE DEPARTMENT OF ENERGY

Research category	Number of projects	Fiscal year 1980 funding (in thousands) [1]
Research directly related to aging: Cellular and organ systems	4	$552
Research indirectly related to aging:		
(a) Lifetime studies of short-lived animals (nuclear)	12	4,095
(b) Lifetime studies of short-lived animals (nonnuclear)	15	3,493
(c) Lifetime studies of long-lived animals	13	6,561
(d) Lifetime studies of human populations (nuclear)	11	7,604
(e) Lifetime studies of human populations (nonnuclear)	2	390
Total	57	22,695

[1] Total operating dollars.

ITEM 6. DEPARTMENT OF HEALTH AND HUMAN SERVICES

JANUARY 22, 1981.

DEAR SENATOR CHILES: I am responding to the letters of October 30 and November 26 from you and Senator Domenici to former Secretary Patricia Roberts Harris requesting information for part 2 of the committee's annual report, "Developments in Aging: 1980." Mrs. Harris asked the Administration on Aging to compile the Department's response. We are pleased to assist in this effort.

The material you requested is enclosed. It includes information regarding the programs and activities of all HHS agencies listed in the October 30 letter. We did not submit information for the Rehabilitation Services Administration, as that agency was transferred to the Department of Education. I understand that the committee has requested information from the Department of Education directly.

I am sending similar letters to Senators Heinz and Domenici.

Sincerely yours,

M. GENE HANDELSMAN,
Acting Commissioner on Aging.

Enclosure.

OFFICE OF HUMAN DEVELOPMENT SERVICES

ADMINISTRATION ON AGING

REPORT FOR FISCAL YEAR 1980

INTRODUCTION

This report is submitted by the Administration on Aging (AoA) in response to the request by the Special Committee on Aging, U.S. Senate, for information on the programs and activities of components of the Department of Health and Human Services relating to the "needs of the elderly" during fiscal year 1980. This information will aid the committee "in tracking the Federal response" to the problems which confront older Americans and is scheduled for publication in part 2 of the committee's annual report, "Developments in Aging."

The Administration on Aging is a component of the Office of Human Development Services (OHDS) which is one of the principal operating components of the Department of Health and Human Services. AoA was established in 1965 in accordance with the provisions of the Older Americans Act of 1965, as amended. The Older Americans Act charges AoA with responsibility for leadership within the Federal Government for building a strong intergovernmental partnership to address the concerns and problems of older Americans.

AoA undertakes a variety of activities in seeking to foster the growth of this "partnership in aging." Title III of the Older Americans Act gives AoA responsibility for aiding States and communities in developing "comprehensive and coordinated service systems to serve older individuals." Funds to support the establishment, maintenance and expansion of these "service systems" are provided through formula grants for social and nutrition services, as authorized in title III. These funds are awarded to State agencies on aging which then make grants on a substate basis to area agencies on aging for the planning and management of services. The area agencies award title III funds to local providers for the actual delivery of services to older persons. Like AoA, State and area agencies are also charged under title III with advocacy responsibilities on behalf of the elderly. The whole range of title III activities is discussed in section I of this report.

In addition to the requirements for the development of service and advocacy systems under title III, the Older Americans Act also contains a number of other provisions which are designed to help AoA improve the life situations of older persons. Title IV, a program of discretionary grants, authorizes funds for training, research, and demonstration activities which specifically focus on the improvement of the services and benefits to older citizens. Similarly, title II, among many other provisions, authorizes evaluation efforts which aid in the improvement of services, as well as a "National Clearinghouse on Aging" which acquires and distributes information on the needs of the elderly and the programs designed to meet those needs. Title VI, which was funded for the first time in fiscal year 1980, provides a system of direct grants to qualified Indian tribal organizations for the provision of services to older Indians. AoA's activities in each of these areas during fiscal year 1980 are discussed in section II of this report. Section II is followed by a series of appendices which include additional information on the subjects covered in sections I and II.

SECTION I: TITLE III SOCIAL AND NUTRITION SERVICES

The purpose of this section is to provide comprehensive information on the services which are available to the elderly through title III of the Older Americans Act. This discussion will focus on title III services and activities in fiscal year 1980.

Section I is divided into three major components. The first of these subsections summarizes the key provisions of title III with respect to services for older Americans. The second describes the elements of the national network of Federal, State, and community organizations by which these services are planned and delivered. The third subsection presents key quantitative and descriptive information on title III services in fiscal year 1980.

A. TITLE III—OVERVIEW

The Older Americans Act of 1965 established a system of State agencies on aging. These agencies awarded grants to start local programs to provide social services to older persons. Since 1965, the act has been amended eight times. The nutrition program was established in 1972. The 1973 amendments required each State agency on aging to divide the State into planning and services areas and to designate an area agency on aging in each area for which an area plan would be developed. Also in 1973, the multipurpose senior centers program was authorized (although funds were not appropriated until 1976). The 1978 amendments consolidated under one title, title III, three programs (social services, nutrition services and multipurpose senior centers) which had been authorized under separate titles. Final regulations to implement the 1978 amendments to title III were published in the Federal Register on March 31, 1980. Regulations for this program are found at 45 CFR Part 1321.

Title III is a formula grant program to provide social and nutrition services to older persons. In fiscal year 1980, $589 million was appropriated for title III.[1] This is about 90 percent of the AoA budget. The amounts of the grants to States are based on the number of persons in each State aged 60 and older. This program is administered through a network of 57 State agencies on aging (including the territories). At the community level, the network includes 602 area agencies on aging and about 25,000 service providers.

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[1] AoA's total budget for fiscal year 1980 may be found in appendix I.

The act requires each State to submit to AoA a 3-year State plan based on area plans developed by the area agencies. State agencies distribute funds on a formula basis to area agencies which purchase nutrition services and a wide range of social services depending upon the needs in the local community. In fiscal year 1980, 54 percent of title III funds were used to provide meals for the elderly.

Title III services are supported with allotments which each State receives in accordance with the formula in section 304 of the Older Americans Act. These allotments are from funds appropriated under title III, part B (social services), title III, part C, subpart 1 (congregate meals) and title III, part C, subpart 2 (home-delivered meals). See appendix II for each State's allotment under these three appropriations.

The most recent amendments to the Older Americans Act were passed in 1978. These amendments provided for a 2-year transition period during which States were allowed to request "waivers" of certain requirements imposed by the 1978 legislation.

During fiscal year 1980, the States and communities completed administrative and program changes necessary to insure full implementation of the 1978 amendments. Considerable progress was made in fiscal year 1979 toward achieving full implementation of the new requirements. For example, the States were given the option of requesting a number of waivers in their 1979 State plans. The number of States requesting all available waivers for the 1979 plan period was 13. However, only one State made a similar request for 1980. Similarly, 36 States requested a waiver of the long-term care ombudsman requirement for 1979, but this number dropped to 22 in 1980.

Thus fiscal year 1980 witnessed continued progress toward full implementation of the new requirements. The State plans submitted for the 1981–83 period (the 1978 amendments made 3-year plans mandatory beginning in fiscal year 1981) commit the States to full compliance beginning October 1, 1980.

Fiscal year 1981 will, therefore, be the first program year in which the requirements of the 1978 legislation will be fully in force. The report which AoA submits to Congress for fiscal year 1981 will provide information on the experience of the States and communities in executing all the provisions of the amended statute.

B. IMPLEMENTING TITLE III—THE NETWORK ON AGING

Many different organizations participate in the effort to implement title III. In addition to AoA, with its central headquarters in Washington and its 10 regional offices, there are the State agencies on aging, the area agencies on aging, and a variety of community-level organizations which, in most instances, are responsible for delivering title III services to the elderly. These network components are discussed in greater detail below.

1. AoA Central Office

Located in Washington, D.C., with a permanent staff ceiling of 140 persons, the AoA central office[2] serves as the focal point within the Federal Government for the concerns, problems, and opportunities which older Americans confront. In this capacity, the central office discharges key coordination and policy development and review responsibilities vis-a-vis other Federal programs. In addition, the central office provides overall guidance and direction for the establishment and maintenance of the community based service systems administered by the States discussed in section I of this report. The central office also plays a major leadership role in planning and administering the discretionary programs discussed in section II.

AoA's central office is organized as follows:

The Commissioner's office is responsible for providing policy, program and administrative direction.

The Office of Management and Policy Control is responsible for preparing the program budget, managing the salary and expense budget, and preparing guidelines for management plans and performance requirements. It also has responsibility for policy guidelines and the preparation of legislative testimony.

The Office of Education and Training manages the discretionary grant programs for all career preparation, continuing education and technical assistance activities.

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[2] An organizational chart for the AoA central office is found in appendix III.

The Office of Research, Demonstrations and Evaluation manages the discretionary grant program for activities related to knowledge building, testing of new programs, evaluating existing programs and disseminating the results. Long-term care activities including policy analysis and research and demonstration projects are conducted by a staff unit located in this office.

The Office of Program Development manages title VI programs, the development of program guidance relating to titles III and VI programs and the development of programs with other Federal or State sector agencies.

The National Clearinghouse is responsible for information and referral systems, reports on population trends and oversight of the SCAN system.

The Office of Public Information produces publications such as Aging magazine, speeches, and displays. It also handles major promotions such as Older Americans Month.

The Office of Program Operations is responsible for providing overall program and management support functions to the 10 regional offices. This office provides program guidance; policy clarification/interpretation; statistical analysis of national program performance reports; and management oversight functions. The 10 regional Program Directors report directly to the Associate Commissioner for Program Operations.

2. *Regional Offices*

AoA has 10 regional offices[3] located in Boston, New York, Philadelphia, Atlanta, Chicago, Kansas City, Dallas, Denver, San Francisco, and Seattle. The regional offices are responsible for providing technical assistance to, and for monitoring the performance of, State agencies on aging. The regional offices are responsible for providing direction and guidance to States in the planning and development of a statewide system of comprehensive services for the elderly.

The regional offices represent and act for the Commissioner in the implementation of national policies and priorities in the development of programs for the elderly. They provide assistance and advise States in development of State legislation to assist the elderly. The regional offices assist States in the achievement of efficient and economical social and nutritional services for elderly persons, especially those with greatest economic or social need. They assist States in the development of 3-year State plans on aging, negotiate resolution of Federal/State issues when those plans are submitted by the Governor, and approve acceptable State plans. Regional offices also assist States in the coordination of public and private resources which serve the elderly, and provide information and policy recommendations to other agencies and organizations which concern themselves with needs of elderly. The regional offices work collaboratively with the staff of the 1981 White House Conference on Aging to support State and regional activities related to the conference.

The regional offices are also responsible for the collection of the performance data which is used in analyzing the effectiveness of the program. They conduct on-site assessments, audit reviews, and generally monitor State compliance with program requirements.

In addition to their responsibilities for title III activities, regional offices administer selected discretionary grants including some model projects and training grants authorized under title IV. They provide information and technical assistance to existing and potential grantees and contractors. The regional offices facilitate coordinated efforts between States and educational institutions, and conduct best practice utilization and demonstration meetings to disseminate information and experience from ongoing research and demonstration programs.

Regional Office Profile

The average regional office has 14 staff, 11 of which are professional personnel. The largest regional office, located in Atlanta, serves eight States and has a staff of 18. There are four regions which have only 13 staff members. These four regions have fewer States, less elderly population or less geographic area to cover.

Regional Offices: Assistance to States and Communities in Service Delivery

The regional aging offices are called upon to provide a variety of expertise and knowledge in the conduct of Older Americans Act activities. For instance, in one region the staff has developed national expertise in providing disaster assistance services during Presidentially declared emergencies. They have prepared a technical assistance manual which provides guidance to States and area agencies relative to the procedures to follow in coping with national declared emergencies. Regional office efforts to help deal with the adverse consequences of rapid community growth (the "boom town" syndrome) provide another example of how these offices can assist in expanding the services available to older persons. One regional office identified 360 communities in its area of responsibility which have a high proportion of retired, low income elderly persons. These communities are experiencing rapid growth due to development of energy resources. In these communities the influx of additional residents, most of whom are highly transient, has driven up living costs, and created housing shortages. At the same time, these new residents have placed additional demands on the local service systems. Such demands have the effect of reducing the attention and the resources the affected communities can allocate to the elderly. The regional office has undertaken an in-depth review of the impact these developments have on the lives of older persons in the affected communities and have prepared publications about the problem which have received nationwide circulation and attention.

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[3] A listing of the 10 regional offices may be found in appendix IV.

3. State Agencies on Aging

Every State (and territory) has a designated State agency on aging[4] to help administer Older Americans Act programs. State agencies on aging are a primary organizational entity for carrying out the purposes of the act. State agencies develop, organize, support and provide technical assistance to area agencies on aging. States administer 3-year plans, and approve and monitor the area agencies' conduct of 3-year comprehensive plans for developing and providing services through grants and contracts awarded to public and private service providers. State agencies, in cooperation with State advisory committees, initiate collaborative agreements with other State agencies, initiate legislative and regulatory proposals to improve service to older people, initiate statewide demonstrations with public and private organizations and agencies, and seek to generate non-AoA, State, and local public and private resources to carry out the purposes of the Older Americans Act in their State. State agencies conduct public hearings, review programs administered by other agencies and represent the interests of older people in the State before boards, commissions and other public and private organizations and agencies.

In 1980, State agencies have been concentrating attention on carrying out the 1978 amendments of the act.

As noted above, a review of 1981–83 3-year State plans indicates that all States are rapidly moving toward compliance with the 1978 amendments. The consolidation of nutrition, social services, and senior center functions is well underway at both the State and area level.

The State agencies faced a significant challenge in the implementation of the 1978 amendments. This challenge included adjustments in planning and service area boundaries, designation of new area agencies, facilitating adjustments in grants and contract agreements between area agencies and service providers, and implementing the new program requirements contained in the 1978 amendments.

Long-term care ombudsman programs are developing in each State and many States are extending the service through designated local representatives. State plans also indicate general compliance with the requirement that 50 percent of the title III social services allotments be spent in three priority service areas: access, in-home, and legal services. Similarly, the plans indicate compliance with the requirement that States spend, in title III funds, an amount equal to 105 percent of what was spent for social services, nutrition services and multipurpose senior centers in rural areas in fiscal year 1978.

Of particular interest are a number of trends toward greater State-level concern for the problems of the elderly. State government continues to supplement Older Americans Act resources with non-Older Americans Act funds. Increasing numbers of States are facilitating the development of organizations of older people by supporting Silver-Haired Legislatures. Some States are assigning new responsibilities, or transferring functions and programs to State units on aging. State agencies are increasingly involved in the development of long-term care services as reflected in section II of this report. State agencies are also extending support and staff resources to State White House Conference on Aging efforts. In general, in spite of inflationary pressures and moderate funding, service levels are being maintained, and in some instances enhanced.

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[4] A listing of State agencies may be found in appendix V.

State Agencies: Profile Data

All 57 States and other jurisdictions have approved State plans on aging. State agencies are organizationally located in State governments either as independent agencies reporting directly to the Governor, or as parts of larger human services agencies. Twenty-nine of the State agencies are independent agencies, and 28 are organizations within larger State agencies. The average State agency employs a total of 31 persons, approximately 10 percent of whom are older persons themselves. There are an average of 15 planning and service areas (PSA's) in each State with designated PSA's. Thus there is an average of 15 subgrants to area agencies which State agencies administer, monitor, and for which technical assistance and related support is provided. In fiscal year 1980, States reported spending approximately $34 million for State agency activities, of which only $22 million (65 percent) was from title III resources. State agency staffs range in size from three in Wyoming to 87 in California, and with a range of fiscal year 1980 outlays (title III funds and State funds) for State plan administration of $145,307 in Wyoming to $3,148,529 in California.[5]

The following includes selected examples of State agency activities intended to enhance and improve services and advocacy for older people.

Virginia.—The Virginia Office on Aging operates as a single purpose, independent agency and currently has 25 employees. The State has been divided into 25 planning and service areas to meet the needs of its elderly population. An AAA has been established in each PSA. In its effort to identify policies and priorities for organizing services to the elderly, it has initiated a legislative task force to study and recommend ways to improve care of the impaired elderly; and has undertaken policy development initiatives with the Council of Higher Education to project long-range labor force requirements for employment and training opportunities for personnel serving the elderly.

In fiscal year 1980, the State agency augmented aging program operations by pooling $4.5 million, and provided employment opportunities for 153 elderly persons at the State and area agency level. Also during this time the following person-units of service were provided in the service categories indicated. Transportation: 90,951; home services, 13,015; legal and related counseling, 5,709; residential repair and renovation, 1,473; information and referral, 5,223; escort, 1,129; outreach, 132,016; all other, 69,564.

The State agency developed an advocacy plan to produce and disseminate budget reports and pertinent materials to lawmakers, State agencies and the general public; conducted public hearings; and coordinated with other State agencies to fully implement a statewide long-term care ombudsman program.

Ohio.—The State agency developed a policy on the housing needs of older people based on an assessment of the adequacy and condition of existing housing resources. This policy will help to initiate statewide action to improve current housing and to develop housing to meet future needs.

Nevada.—The State agency has undertaken a long-term effort to establish a senior center in every community in the State. Over the past several years, the State has garnered a great deal of community support for providing social services to older persons. This effort has resulted in considerable volunteerism in the local communities through provision of materials and/or labor to build or refurbish buildings for this purpose. Now every community throughout the State has such a facility.

Utah.—State agency on aging has initiated a new program entitled the "alternatives program." This is a joint initiative with the State medicaid program, whereby each area agency has appointed a coordinator who is responsible for working with the medical community in evaluating the social service needs of older persons who are about to be placed in a nursing home. Where possible, the older person has been linked with title III services such as transportation, home delivered meals, etc. In a number of cases, this has avoided or considerably delayed nursing home placement.

Washington State.—The State agency on aging has undertaken a unique information and assistance program implementing a case mangement system for older persons. This program is administered through the area agencies on aging and is designed to maintain the option presently available to older persons relative to living arrangements, life style, etc. The system provides for an individual needs assessment, development of a service plan, arrangements for obtaining the needed services and followup to assure appropriateness of the service.

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[5] Exclusive of the island jurisdictions, but including Puerto Rico and D.C. A table of title III allotments for State plan administration may be found in appendix VI.

Pennsylvania.—The State agency on aging in cooperation with the Department of Public Welfare administers a domiciliary care demonstration program through area agencies in 28 counties. Supported by State funds, title XX funds, SSI and medicaid, the program included 720 older people placed and supervised in 672 foster and group homes in 1980. The State agency became a cabinet-level department in 1978. In 1980 transportation services supported by State lottery funds were extended to rural areas under legislation supported by the department. The State has also initiated a new statewide consumer discount program for older people. The department also joined with the State Health, and Public Welfare Departments to initiate a long-term care development plan.

Missouri.—In the State of Missouri, the title XX program and responsibilities for licensure and regulations of nursing homes were transferred to the State agency on aging.

Florida.—A home care program for the elderly, initiated in 1978, was designed to encourage the provision of care in family-type living arrangements in private homes for three or fewer elderly relatives or nonrelatives. The program is targeted for low-income persons, aged 65 or older, who are most at risk of institutionalization. Services provided include basic support and maintenance, housing, food, clothing, incidentals, and personal care. Available through an adult services counselor are counseling and health support, family preservation and assistance counseling to relatives providing services, respite care, and adult day treatment center services. During the past year, 1,402 elderly benefited from the home care program; a waiting list included an additional 675 potential recipients for the services.

Washington, D.C.—The State agency has been instrumental in establishing a long-term care service program which joins inpatient and outpatient care and services, individual diagnosis, assessment and case planning.

4. Area Agencies on Aging (AAA's)

Under title III subgrant awarded to them by the State agency, area agencies have similar leadership and service development responsibilities within their planning and service areas as the State agencies do within the States. Through planning, coordination, service development and advocacy activities, they try to increase and improve the secrets and benefits which local agencies provide the elderly in the PSA. Area agencies play a leading role in coordinating the development of comprehensive local service delivery through interaction with existing public and private service providers, and through financial support via subgrants and contracts to service providers in order to expand the services of those providers to meet older persons' needs. In addition, area agencies vigorously seek to redirect the use of nontitle III resources (e.g., title XX funds, local nonprofit funds, etc.) to assure that older persons receive maximum benefit from those resources. In carrying out these responsibilities, area agencies have major administrative duties to perform in managing subgrants and contracts awarded under their area plan to local service providers, and assuring that title III funds are used for appropriate and allowable purposes. Similarly, they provide technical assistance and related support to service providers in the community to improve the management and quality of services available to older persons.

Area Agencies on Aging: Profile Data

There are currently 602 area agencies on aging operating in 44 of the 57 States and other jurisdictions. The remaining 13 jurisdictions operate as "single PSA" States which means that the entire State is considered a planning and service area for the purpose of planning, delivering and monitoring services to the elderly under title III.

The average area agency employs a total of 13 persons. This includes both those supported with title III resources and those paid with other funds. Of these 13 staff members, approximately three are older persons themselves.

In fiscal year 1980, each area agency (and the social and nutrition service providers which it funded) were supported, on the average, by over 400 volunteers. Thus, more than 264,000 volunteers work locally in AoA-supported programs under the Older Americans Act.

About 60 percent of the all area agencies are organizationally located in local government agencies, with the remainder being located in private agencies. A typical planning and service area served by an area agency included five and one-half counties, with approximately 51,000 older persons living in the PSA. In the average PSA in fiscal year 1980, approximately 14,000 older persons were provided social services, and 4,[illegible]00 persons received congregate and/or home delivered meals.

Like State agencies, area agencies engage in a wide variety of efforts to improve and extend services, in many instances using non-AoA public and private resources. Area agencies were involved in the conduct of thousands of community forums preparatory to the 1981 White House Conference on Aging. Area agencies have also been instrumental in efforts to colocate services to make them more accessible to the elderly. For example, over 1,600 nutrition sites are now located in housing facilities serving the elderly. Numerous area agencies have provided staff and resources to support local ombudsman programs to extend the service to older people in their areas. Area agencies are directly involved in implementing the department's long-term care demonstration program. There is an extraordinary diversity of local experience and a growing degree of cooperation between area agencies, public and private agencies, local public officials and particularly older people which is at work in thousands of communities across the Nation. The following provides a profile of an AAA at work in a large city. Examples of AAA activities in other communities will follow the discussion of the Buffalo, N.Y., program.

Erie County, N.Y.—The Erie County (Buffalo) Area Agency on Aging operated with a budget in 1980 of $6.6 million. Of the total, 58 percent ($3.8 million), came from Older Americans Act funds. The Erie County AAA serves a planning and service area covering 1,029 square miles with an elderly population of 169,800. Twenty-five percent of the elderly population is estimated to be low income. The area agency operates with a paid staff of 75 full- and part-time persons.

Some of the services provided under the auspices of the Erie County Area Agency in 1980 included:

—22,425 hours of homemaker services to 160 people—with an average of 140 hours of service per person.

—2,377 units of home health services for 317 clients—these services include environmental modifications for impaired persons to make their homes safer and accessible.

—Other support services in the home to 2,560 high risk elderly. These include 166,000 units of telephone reassurance and 44,430 units of services such as friendly visitors, errands, shopping assistance and letter writing.

—55 workshops on retirement planning attended by 2,350 persons.

—Legal services to 2,100 persons.

—160 persons placed in jobs subsidized with funds authorized under the "community service employment for older Americans" program administered by the Department of Labor. In addition, title III funds were used to place 390 older persons in full- and part-time unsubsidized jobs in the private sector.

—Provision of 714,310 congregate meals to 9,800 persons and 326,000 home delivered meals to 1,250 persons.

—121,075 trips to congregate meal sites, stores, medical facilities and other community services (46 percent of trips were for medical care).

In response to congressional mandates and local needs, area agencies on aging seek to coordinate and enlist community support to improve and expand services and benefits for older residents. Some of the Erie County AAA's 1980 activities for this purpose were:

—Development of new funding sources which increased resources by 14 percent.

—Initiation of a new needs assessment for a 5-year period to promote more effective long range planning.

—Establishment of seven clusters of community service focal points to facilitate coordination and colocation of service.

—Provision of technical assistance to 17 senior centers to assist in programing.

—Monitoring/administration of 90 contracts, 50 of which were major service contracts.

—Began implementation of case management plan to serve at least 400 high risk, impaired older individuals.

The Erie County Area Agency budget comes from a variety of sources in addition to title III. The county provides approximately 20 percent of the funds. ACTION provided $100,000. Title XX funds amounted to $589,643. Department of Labor funds came to $900,000. State and county mental health agencies provided $150,000. New York State appropriated $80,000 for recreation services and $413,000 for community services.

In summary, the activities of Erie County AAA have contributed significantly to improving and expanding community support for the well being of older persons in that locality.

Area Agency Activities and Priorities: Other Examples

In addition to the many creative programs and initiatives undertaken by the Erie County AAA, examples can be cited of similarly successful efforts by AAA's in other communities. The following illustrate how area agencies are working with both the public and private sectors to expand services to the elderly in Central Texas; Jacksonville, Fla.; Baltimore County; New York, and Spokane.

Central Texas.—The Central Texas Area Agency on Aging entered into a contract with four other community agencies to provide emergency in-home care for needy elderly. The organizations participating with the Central Texas Area Agency include the Texas Department of Human Resources, Home Care Health Services, Inc., Senior Citizens Activities, Inc., and Hill Country Community Action Association, Inc. Services include personal and household tasks, and escort service for medical care.

Twenty-nine senior centers located within the planning and service area are the intake points. Center directors report tentative clients. The Department of Human Resources assesses each individual case and issues a service order to Home Care Health Services to provide paid assistance to the client. Senior centers then arrange for volunteers to supplement the paid assistance. This arrangement was initiated by the area agency on aging to pool resources in order to help the community to provide needed home care services and prevent premature institutionalization.

Jacksonville.—The City of Jacksonville, Fla., has completed construction of a new citywide multipurpose senior center through which public and private agencies provide a wide range of health, social, educational, and recreational services to the older people of the city.

Baltimore County.—Baltimore County, in cooperation with county officials and older residents, has developed a countrywide plan to renovate up to 28 senior center facilities. This ambitious and unique effort joins the AAA, county officials and architects with neighborhood citizens planning groups from the beginning in site selection, use of space design, and services development.

New York.—On Staten Island, the New York City AAA has developed a fixed route portal-to-portal transportation service joining a wide variety of transportation providers. The program is highly successful and has dramatically extended transportation for shopping, medical care and/or health and social services.

Spokane.—In Spokane, Wash., the AAA and the community mental health center (CMHC) have jointly developed a case management and service program to reach and serve the mentally and physically impaired. In 1980, over 25 percent of the clients served by the CMHC have been older people.

For the most part, social and nutrition services supported under title III are delivered by some 25,000 community-level providers, including both public and private organizations. Within the private sector, voluntary and "for-profit" agencies are used. In some instances, the provider is a special purpose organization dealing exclusively with the concerns and needs of older persons. In other situations the provider may service a number of constitutent groups, including older persons. In all instances, however, the providers are selected because of their expertise, their capacity to deliver the services older persons need, and because of their commitment to helping the elderly.

C. TITLE III OF THE OLDER AMERICANS ACT—SUPPORT FOR COMPREHENSIVE AND COORDINATED SERVICE SYSTEMS

The different types of services made possible by title III are discussed in this part of section I. A brief survey of advocacy activities at the State and community levels will be presented first, followed by a discussion of services in four specific categories (access, community/neighborhood, in-home, and those provided in institutions) which title III supports.

1. Advocacy Activities

Title III charges both State and area agencies with a broad range of advocacy responsibilities. Three major areas of advocacy involvement, the "pooling" of non-Older Americans Act resources in support of title III goals, the efforts to secure improvements in State and local legislation and government programs for the benefit of the elderly, and the work of "silver haired legislatures" will be discussed below.

Pooling.—As indicated above, non-Older Americans Act resources are a key part of the State funding base for programs supported with title III monies. The following table indicates the overall degree of success which State and area agencies have experienced in fiscal year 1980 in securing non-OAA funds for title III activities. In interpreting these data on pooling, it should be noted that, in fiscal year 1980, title III appropriations for social and nutrition services totaled $567 million.

(In millions)

	1979	1980
Local resources	$123	$157
State resources	66	115
Federal resources	248	389
Total resources pooled	437	661

Advocacy to Influence Legislative Change

The Older Americans Act requires State and area agencies on aging to assume an active advocacy role on issues including those associated with State and local legislation which affect older persons. The legislative advocacy activities of the Washington State agency illustrate how State agencies across the country can serve as effective and visible advocates to influence legislative change on the State and local level. The Washington Bureau on Aging employs an attorney who identifies and monitors proposed legislation and legal issues which affect older persons. The State agency attorney provides technical assistance to the aging network to encourage legislative changes important to the well-being of older persons in the State of Washington. This attorney compiles information which is used by members of the State legislature and other legislative bodies when considering aging issues. The attorney attends legislative hearings and committee meetings and serves on task forces such as one which deals with the legal rights of older persons in the context of mental health issues.

Other examples of such 1980 State legislative achievements in the field of aging include:

- —A Maryland law which provides relief for persons 65-plus on the State tax of pensions.
- —A Massachusetts law which provides for $1 million program to purchase condominiums for needy elderly residents of converted apartment buildings.
- —A Massachusetts law which indexes eligibility for State funded home-care services to social security increases.
- —Pennsylvania legislation to license boarding homes for the elderly.
- —Nursing home ombudsman access legislation passed in New York and Kansas.
- —A Colorado law requiring the reporting of suspected abuse, neglect or exploitation of older persons in the community and in institutions to be followed up with protective services. The law provides penalties for failure to report elder abuse.
- —A Kansas elder abuse law which also requires reporting.
- —A Delaware law which provides State funds to help low income older persons to pay prescription medicine costs.
- —Florida legislation which expands patients' rights in nursing homes, establishes a nursing home rating system, provides increased optional State supplementation for nursing home residents, and mandates certification of adult congregate residence.

Silver Haired Legislatures

A number of States have undertaken a variety of efforts to establish ongoing "Silver Haired Legislatures." Simulated legislative sessions are held to identify and recommend State legislative innovations or changes. In some States, the elderly have developed State agendas for legislative action on the part of the official State legislature. They obtain legislative sponsors for introduction of legislation, assist in the drafting of bills and advocate through elected officials for passage.

In Florida, in 1979, 10 bills which were passed by the Silver Haired Legislature were introduced into the State legislature, favorably reviewed and subsequently enacted. The issues addressed included waiving tuition for the elderly, regulations for adult congregate living facilities, labeling of prescriptions with the expiration date, State retirement for those over 60, condominium conversion, cost-of-living increases for State retirees (the first such increase ever received), electric utility rate relief, health insurance, and training of gerontological professionals in State colleges and universities in Florida. In 1980, the Silver Haired Legislature passed 12 bills, 10 of which will be introduced into the forthcoming session of the State legislature. During 1979–80, the State Office on Aging provided $60,000 from title III funds for support of the Silver Haired Legislature.

2. Serving Those In Need

Under title III, a variety of social services (including such services as transportation, home health, legal, residential repair and renovation, information and referral, and escort and outreach) and nutrition services, were provided to older persons particularly those disadvantaged by economic or social need, in 1980. The range of services offered can be grouped into four categories: access, community, in-home, and institutional. Each of these will be discussed below.

Access services include such services as transportation, outreach, information and referral, escort, individual needs assessment and service management. In 1980, there was a particular demand for access services, as indicated by the estimated 3.5 million person units of service provided in the area of information and referral and the more than 2 million estimated units in the transportation area. In other access services, 1,472,000 (estimated) person units of service were provided in outreach and 210,000 (estimated) in escort services during the past year. The success and creativity of programs in facilitating access to services for older persons are illustrated in the following examples.

A unique radio network, termed "New Aging Radio," and tailored to the needs of the elderly, was established in Ohio with the assistance of the Ohio Commission on Aging. The network offers an entertaining way of providing specific information about aging-related services offered in Ohio. Programs discuss a broad range of topics including finances, health, leisure, legal matters, housing, and new lifestyles. Listeners are invited to write in with questions, concerns, and suggestions. The network is designed for two-way communication as many in the audience lead solitary lives. The conversational tone also encourages audience participation. Listeners are given a telephone number which they can call for further information.

An emergency alarm system called "Lifeline" is now being used by vulnerable elderly and handicapped people living independently at home in Fulton County, N.Y., with assistance from funds provided by the county office on aging. "Lifeline" provides 24-hour access to help at the push of a button. The system is based on a small box that plugs into the phone and automatically dials the number of a 24-hour emergency station. An emergency operator is automatically contacted and calls to find out what the problem is. If the person does not answer, a predetermined list of nearby helpers is called for an immediate response. This cooperative community effort has also encouraged service providers and other groups such as churches, service organizations, and public agencies to identify the most vulnerable residents of the community and increase their access to both community and emergency services.

In Florida, a "companion service" provides a personal in-home emergency service which senses when a person needs assistance and automatically summons help via trained personnel. It is based on the installation of a private phone line and strategically placed sensors in the home. An assist button, which can be carried, allows a person to contact the communications center. Some 800 individuals, 85 percent of whom are elderly, are being served in Pinellas County, Fla., an area encompassing St. Petersburg. Beginning in January 1981, a new project, with support from title III–B funds, is being initiated in Tampa in Hillsborough County for 150 elderly persons.

Community services include such services as residential repair and renovation, congregate meals, legal services, continuing education, day care, recreation, and the acquisition, alteration, and renovation of facilities to be used as multipurpose senior centers. In 1980, estimates indicate that 315,000 person units of service were provided for legal services and 80,000 for residential repair and renovation. Congregate meals were offered through 1,178 nutrition projects which operated 12,475 sites located throughout the country. Nearly 3 million elderly participated in the nutrition program in 1980, two-thirds of whom were low-income, and one-fifth from minority groups. Over 123 million meals were served to those older persons who came to congregate settings, located in senior centers, churches, schools, apartment houses, and other sites.

Following are some examples of programs which highlight the development and coordination of community services in several areas during the past year.

Supported by title III-B Older Americans Act service funds and county revenue sharing money, a mobile counseling team called PACE (psychological alternative counseling for elders) started a year ago in Orange County, Calif. The project now meets with approximately 1,600 elderly at 21 centers throughout the county. One of the project goals is to involve the elderly in helping each other. PACE and the county department of mental health have begun intensive programs to train older persons to become peer counselors at nutrition sites and senior centers. This training demands considerable commitment and skill development on the part of participants. Through the use of trained volunteers, community mental health resources are expanded to help troubled older persons live independent, dignified lives.

Harbor Springs, Mich., is integrating older persons in the local high school program. Joining the combined middle-high school student body of 916 boys and girls in grades 6 through 12 are an estimated 70 men and women aged 65 and over. The older people mingle with the younger, joining classes either as students or instructors and taking part in extra-curricular activities as well. School buildings have found new life as senior citizen centers around the Nation, but Harbor Springs is providing total classroom integration of the older and younger generations. The local senior center is moving from a church basement to renovated quarters in the Harbor Springs High School. The Northwest Michigan Area Agency on Aging helped finance the move and renovations with a $16,000 grant.

The category of *in-home* services includes such services as home health, homemaker, preinstitutional evaluation, casework, counseling, chore maintenance, visiting, shopping, letter writing, readers, telephone reassurance, and home-delivered meals. In 1980, an estimated 630,000 units of services were provided to elderly persons in their homes. In addition, more than 40 million meals were delivered to the homebound elderly, an increase of nearly 30 percent over the number delivered in the home in fiscal year 1979.

Some of the ways in which vulnerable older persons and their families were assisted by services provided in their homes are illustrated in the following examples:

—An innovative and successful program which provides respite care for older persons was established by an area agency on aging in Massachusetts. "Respite care" is directed at families which are involved in the 24-hour-a-day care of older persons. The program is filling a real need in providing support for the efforts of families involved in the constant care of an elderly person, most of whom are between the ages of 75 and 80. Under this program, CETA workers are utilized to provide services to the family, allowing up to eight hours each week of time away from the home on a regular basis. In addition, the elderly person benefits from outside companionship and conversation. Because of the CETA grant there is no charge for those determined to be in need of the services. The program is viewed as a creative and cost-containing means of helping families care for the sick and/or disabled elderly on a part-time or emergency basis.

—The East Central Florida Area Agency on Aging finalized plans for contracting with Hospice of Orlando to provide home care for terminally ill elderly. The District VII Area Agency on Aging was the first in the State to offer a range of all services available through hospice programs and estimates suggest that more than 100 clients will receive inter-disciplinary services which will provide for psychosocial, therapeutic and health care. Florida is the first State to have enacted a unique law regulating and recognizing Hospice as a total care program for the terminally ill.

The fourth category of services, *institutional*, are those services provided to residents of long-term care facilities, emergency shelters, and other congregate living arrangements. Institutional care services are discussed both in terms of the ombudsman program below and in section II under discretionary programs.

The Administration on Aging's nationwide long-term care ombudsman program is now in its fifth year of existence. Information provided to AoA by State ombudsman programs shows marked development of the program. This development is indicated by:

(1) Considerable expansion of the program to the local and area levels, with a total of over 250 local ombudsman programs by the end of 1980;

(2) An increase in the number of States which have passed ombudsman enabling legislation from 3 in 1975 to 11 in 1980; and

(3) The fact that almost half the States (23) have secured access for ombudsman program representatives to long-term care facilities and residents of those facilities.

The 1978 amendments to the Older Americans Act required every State to have a long-term care ombudsman program and specifically defined ombudsman functions and responsibilities. There are three primary sources of funding for the ombudsman program at the State level: social services money under the Older Americans Act (title III-B), State money, and the State advocacy assistance grant. Long-term care ombudsmen throughout the country are involved on a daily basis in resolving a range of problems affecting residents of long-term care facilities. Such problems or complaints often serve as the basis for the development of major new legislation or regulatory changes. Sometimes resolution requires only bringing the situation to the attention of someone who can affect the needed change. Whether a complaint is simple or complex, the critical factor in its resolution is often the individual involvement and sustained focus that the ombudsman can provide. The following examples of actual cases handled by ombudsmen in a variety of States demonstrate this fact:

—A resident of Arizona wrote to a Federal official complaining about deplorable conditions in an Arizona boarding home where her mentally retarded uncle resided. The niece's letter was forwarded to the Arizona ombudsman along with a request that he investigate conditions at the facility and determine whether Federal funds were involved. The ombudsman made an unannounced visit to the boarding home and confirmed that the barracks-type structure was filthy (goats and pigs were actually living inside the structure), the plumbing was non-functioning, residents were locked out in the morning to sit outside all day, perishable food was not refrigerated, and several fire hazards were evident. All 28 of the former State mental hospital patients who reside there received Federal supplemental security income. As a result of the ombudsman's intervention, the operator's business license was revoked and all residents were transferred to another facility. More importantly, the ombudsman convinced State officials of the need for boarding home regulations, and subsequently, the State adopted standards (which the ombudsman helped to develop) for all such facilities in the State.

—A nursing home resident in Idaho registered a complaint with the State ombudsman concerning a notification she received in June that, as of July 1, she would be ineligible for medicaid because of a 14.4 percent raise in social security benefits. A check with the sub-State ombudsman revealed that approximately 112 nursing home residents would also lose their eligibility for medicaid reimbursement for nursing home care. Investigation revealed that the State medicaid program had issued a policy announcement stating that ceilings for medicaid eligibility would not be raised to reflect the July social security increase. After negotiation between the ombudsman and the medicaid agency, the policy announcement was rescinded and eligibility ceilings were raised to reflect the 14.4 percent increase in social security benefits.

—In response to a complaint letter, the State ombudsman in Wisconsin visited a resident confined to bed. The resident was an alert man who had been placed in a room with another resident who didn't talk. Eight months earlier this resident had been up and using a wheelchair. With an explanation of, "The wheelchair is needed by someone who needs it more than you do," a staff member had taken the wheelchair away. The resident was put to bed where he remained for 8 months. During this period, the resident was repeatedly told by staff that complete bed rest had been ordered by the physician and was essential. When questioned by the ombudsman, the director of nursing admitted that there was no physician order for bed rest and that she didn't know why the resident was not allowed to be out of bed. Another wheelchair was then issued to the resident.

The Administration on Aging is charged with a number of responsibilities regarding the planning and delivery of services to the elderly, as discussed in section I. Technical assistance to the network components which actually coordinate and manage the service delivery efforts is one such responsibility. Monitoring the quantity and quality of title III services is another.

In addition to these activities, AoA is also responsible for assisting State and area agencies to carry out new service development initiatives through the use of its discretionary programs. These include the research, demonstration, and training programs authorized under title IV of the Older Americans Act. In addition, the evaluation activities authorized under title II are also part of this effort, as is the program of the National Clearinghouse on Aging (another title II activity). Finally, the direct grants to Indian tribes which are authorized by title VI and funded for the first time in fiscal year 1980 are also in the service development category. These activities are discussed in section II of this report.

SECTION II: BUILDING THE KNOWLEDGE AND PRACTICE BASE FOR MORE EFFECTIVE SERVICES—AoA DISCRETIONARY PROGRAMS

The ongoing transformation of the population of the United States is the result of extraordinary social progress in the century. Since 1900, we have extended life expectancy from birth by more than 60 percent. The next half century will bring a continued shift in the population structure due to declining birth rates and extended longevity. We are thus in the midst of significant social changes, one of which is the addition of new generations of older people.

These dramatic population changes present us with significant challenges and opportunities. As a Nation we need far more information than is currently available concerning the needs of the elderly, the services and benefits required to address those needs, and the resources the elderly can themselves provide to help in resolving both the issues associated with old age and also the significant questions concerning other population groups.

AoA's discretionary programs, authorized under titles II, IV, and VI of the Older Americans Act, offer unique opportunities to target resources in effectively addressing these questions. The evaluation program authorized under title II can contribute significantly to this effort, as can the activities of the National Clearinghouse on Aging. Through the research, training and demonstration activities which are supported with title IV resources, AoA can continue to shape and support the agenda of inquiry which this country must sustain if we are to secure the answers we need regarding the basic issues associated with our changing demographic patterns. Finally, the insights gained through the implementation of the new title VI program for services to older Indians can add to our understanding of how services are planned, managed and delivered.

The basic roles and functions of AoA are established in title II of the Older Americans Act. The provisions in title II and the subsequent authorities and mandates establish a formidable agenda which can be aggregated into four primary areas of responsibility. These areas are: (1) The societal integration of older people through policy development and advocacy; (2) serving those in need; (3) long-term care; and (4) improving capacity through application of knowledge. The following material about AoA's discretionary programs is also organized in terms of these same four areas. Two additional programmatic and research efforts are also included below. One is the implementation of title VI, in which, for the first time in 1980, awards were made to Indian tribal organizations for the provision of social and nutrition services to elderly Indians. The last activities described are ongoing evaluation studies to assess the effectiveness of programs designed to meet the needs of older Americans.

A. SOCIAL INTEGRATION OF OLDER PEOPLE THROUGH POLICY DEVELOPMENT AND ADVOCACY

1. National Policy Development

AoA assists in shaping national policies on critical issues by providing forums for consensus building. This occurs through the conduct of national policy conferences in selected areas. In addition AoA impacts on national policy through knowledge gained from examination of basic social issues and the effects of social, political, or economic intervention. This examination occurs through AoA sponsored social policy research and social policy demonstrations.

AoA also aggregates knowledge and practice in areas through support for special emphasis policy study centers.

Policy Conferences

The 1981 White House Conference on Aging (WHCOA) wil provide an opportunity—for, older Americans together with public and private interest groups—to formulate a national perspective on policies affecting older persons. The Conference will produce a final report which must express "comprehensive coherent national policy on aging together with recommendations for implementation of the policy." The goals of the White House Conference converge with the functions of AoA. Therefore, AoA in 1980 supported seven mini-WHCOA preconferences in special areas, 51 State conferences, and four regional WHCOA hearings.

AoA also conducts national policy review and development conferences in areas of national policy significance. The objectives are: (1) To review and integrate research findings; (2) to review current practice; (3) to disseminate knowledge; (4) to stimulate best practice replication in the public and private sector; and (5) to provide new policy and program options. Each conference involves: (1) Identification of policy questions and problems; (2) preparation of policy background papers; (3) review and critique by invited experts (governmental officials, academicians, public and private agency administrators); and (4) submission of reports and recommendations to AoA. These conferences provide a flexible vehicle through which the government can assemble the most knowledgeable individuals in and out of government to examine major social policy problems of immediate and long-range importance. In 1980, AoA funded 13 conferences focusing on such issues as abuse or neglect of older persons, age discrimination, long-term care, and older women.

Policy Research and Demonstrations

Social scientists in every discipline have identified extensive and far reaching changes in the social structure with profound effects on the elderly. It is vital to identify and analyze the impact of these changes on existing public and private structures to allow planned development and redesign of policy and services for the elderly of the future. In 1980, AoA funded 14 projects designed to further policy analysis to promote the integration of the elderly into society.

An example of social policy demonstration activity in AoA is its small business initiative. During fiscal year 1980, AoA took the first steps in developing a multiagency, public and private sector initiative that is designed to address the needs of older people for increased economic opportunities and the continuation of active and productive roles in society.

Policy Centers

The AoA has funded national aging policy study centers, mostly based in academic institutions, for the purpose of providing interdisciplinary study of six major policy areas. The centers and their areas of emphasis are listed below:

Income maintenance—Brandeis University.

Housing and living arrangements—University of Michigan.

Employment and retirement—University of Southern California.

Education, leisure and continuing opportunities for older persons—the National Council on Aging.

Older women—the University of Maryland.

Health care for the aging—University of California of San Francisco.

The national aging policy centers will aggregate and synthesize AoA and non-AoA research, and demonstration findings for: (1) Introduction into teaching curricula; (2) defining future research agendas; and (3) examining government program and policy implications.

Policy Development: Synthesis

AoA's research, conference and policy development activities are interrelated and coordinated. Research is directed at knowledge development. The policy conferences utilize research findings as one source of information for policy and program formulation and for knowledge dissemination. In 1979, for example, AoA funded research projects on abuse and neglect. During fiscal year 1980, the results have been analyzed and a report is to be released. Legal Research and

Service for the Elderly (Boston) will hold a conference to review abuse and neglect of older people by families and in institutions. This conference on abuse and neglect will utilize research results, examine demonstration projects on abuse and join academicians and State policymakers in a review of literature and State protective service laws and programs to protect abused adults. Findings will be made available to the WHCOA and the policy centers.

Another example is in the housing and living arrangements. As indicated above, AoA supports a National Aging Policy Study Center on Housing and Living Arrangements at the University of Michigan Institute of Gerontology. This center, the basic experimental and developmental center for AoA in housing, will study such special problems as the housing needs of frail and chronically impaired older persons and rural older persons and energy factors.[6]

2. *Discretionary Support for Advocacy—Individual Rights and Responsibilities*

The goal of enhancing the freedom and well-being of individual citizens is supported by the use of law to establish and protect rights and through the establishment of programs to enhance well being. As noted by the U.S. Civil Rights Commission (in its report to the Congress, Age Discrimination Study December 1977), the use of chronological age carries the burden of imposing value and worth to classes of individuals on the basis of age. It has fostered and sanctioned private and public actions which deny individuals the right of choice in such crucial matters as work and retirement. Individuals are denied access to services and assistance through the application of cost/benefit determinations according to age.

State Advocacy Assistance Grants

The Congress began a process of eliminating discrimination against the elderly with the enactment of the Age Discrimination in Employment Act, the enactment of the Age Discrimination Act, and the 1978 amendments to the Older Americans Act expanding publicly supported legal services for older people.

Older persons confront pressing needs for legal advice and representation to protect their rights and to obtain benefits and entitlements. These include rights to public benefits, pensions and other retirement income, rights to employment without age discrimination, rights to federally funded services without age discrimination, rights to housing and health care, rights of institutionalized older persons, and rights to alternatives to institutionalization. Each of these problems has a legal component and may require a legal remedy. In some cases class actions are an appropriate means for addressing the problems faced by our older population. Therefore, the Administration on Aging has consistently sought to encourage the development and expansion of legal service activities on behalf of the elderly.

As noted in section I, the long-term care ombudsman program is now a mandated State-administered program. The ombudsman program must: (1) investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities; (2) monitor the development and implementation of laws, regulations, and policies with respect to long-term care facilities in that State; (3) provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities; and (4) train volunteers and promote the participation of citizen organizations to participate in the ombudsman program.

Systems to implement the legal services and ombudsman services mandates are now firmly in place. The Administration on Aging has promulgated regulations for legal services and the ombudsman program. As indicated previously, AoA is using discretionary resources to implement these activities which are described below.

Beginning in 1978, grants ranging from $50,000 to $137,000 per year have been made to the State agencies on aging to assist them in developing systems to provide advocacy for individual older persons and advocacy on issues which affect large numbers of older persons. Grants totaled $2,762,558 for fiscal year

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[6] AoA devoted the following discretionary resources for national policy development in the ways described above: Policy conferences, $2,787,000; policy research and demonstrations, $1,745,000; policy centers, $959,000.

A detailed listing of projects under this category is contained in appendix VIII.

Note: Of the $2,787,000 for conferences, $678,000 was for national policy conferences and $2,109,000 for activities related to the 1981 White House Conference on Aging.

1979, and $2,816,769 for fiscal year 1980.[7] The States have used these funds to support development of their legal services and long-term care ombudsman programs and to promote a variety of other special advocacy initiatives. Guidelines for 1980–81 focus on objectives which will help the States implement the specific provisions of the Older Americans Act related to development of the legal services and ombudsman programs.

For the ombudsman program these include activities to secure access for ombudsmen to facilities, residents and residents' records; working with area agencies on aging to develop sub-State ombudsmen programs; involving community groups and volunteers in the ombudsman program; and establishing statewide uniform complaint documentation systems.

For legal services, activities focus on developing policies and procedures for implementation of legal services requirements of the Older Americans Act; coordinating area agencies on aging and title III funded legal services programs; and coordinating area agencies on aging and title III funded legal services programs with private bar and law school resources and with nonlegal services advocacy, such as ombudsman programs.

Biregional Support Centers for Advocacy Assistance

Five advocacy assistance support centers help the States to execute their mandate to advocate for older people, expand legal services, and implement the long-term care ombudsman program. The centers provide materials, research, and lawyer backup to the network. The centers are staffed by experienced professionals in the field of aging, lawyers, and paralegals who can design and deliver materials, training, and support to all States in their regions.

The work of the centers includes:

—Holding training conferences for State legal services and ombudsman personnel to provide them knowledge and capacity in substantive areas (e.g. medicare, food stamps, age discrimination).

—Helping States design statewide training systems for advocates, providing packaged training materials for States, and training trainers in each State.

—Providing counseling and materials on setting up services delivery systems, including model designs, model contracts, evaluation instruments, and funding proposals.

—Assisting States in establishing linkages to Legal Services Corporation projects, bar association, law schools, and other components of an advocacy system.

—Conducting workshops in every State on legislative issues, techniques for legislative advocacy (e.g. silver-haired legislatures), and model legislation; and

—Providing analysis of law reform issues and assistance in pursuing law reform litigation and other remedies for elderly clients in the courts.

National Task Force and Support Program

Discrimination against older people is reflected in policy and practices of public and private institutions which are beyond the reach of State and area agencies. State and area agencies have advocacy responsibilities that go beyond legal services and ombudsman programs. State agency plans recommend objectives to assist older people in the protection of their rights under the Age Discrimination Act of 1975, and under the Age Discrimination in Employment Act of 1967, as amended; to implement section 504 of the Rehabilitation Act of 1973, as amended; and to increase access of older persons to benefits programs under specific Federal and State entitlement programs.

During 1980, the White House established a Standing National Task Force on Older Americans Civil Rights and Age Discrimination. Members of the Task Force are the ranking officials of the signatory agencies: the Office for Civil Rights (DHHS); the Equal Employment Opportunity Commission; the Legal Services Corporation; the American Bar Association; the Administration on Aging; and the U.S. Commission on Civil Rights. The parties signed an agreement to promote full implementation of the two antidiscrimination statutes, to promote the expansion of legal representation and the development and implementation of the ombudsman program, and to enhance public knowledge and understanding of needs and rights of older people.

No AoA discretionary funds were committed to this effort in fiscal year 1980.

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[7] The State advocacy assistance grants represent combined fiscal year 1978 and fiscal year 1979 funds, and fiscal year 1979 and fiscal year 1980 funds, for program years 1979 and 1980 respectively.

Additional Legal Service Support

In addition, AoA has entered into a cooperative agreement with the Legal Services Corporation to provide:

- —Leadership, backup, clearinghouse, and coordinating functions for biregional centers and the AoA advocacy system (to be performed by the National Senior Citizens Law Center).
- —Access for AoA advocates to LSC's national clearinghouse.
- —Two major national conferences on medicare litigation strategies and long-term care advocacy.
- —Special projects carried out by LSC national support centers for direct substantive issue support: and
- —Access to the sophisticated skills, expertise, and materials of LSC's 17 national support centers.

During fiscal year 1980, AoA also funded:

- —The *American Bar Association* to stimulate the involvement of its membership in the provision of legal services for the elderly.
- —The *National Citizens Coalition for Nursing Home Reform* to promote and organize citizen involvement to improve the quality of life for nursing home residents.
- —The *Colorado Congress of Senior Organizations* to establish a task force for the purpose of studying the effectiveness of and need for outreach and services to the elderly in Spanish-speaking communities in Southern Colorado and Northern New Mexico.

The Administration on Aging and ACTION agreed to promote the direct involvement of older people and organizations of older people as lay advocates. ACTION and AoA will jointly issue guidance and provide technical assistance promoting the direct involvement of organizations of older people and volunteers in developing and implementing initiatives under the agreement.

There are now approximately 350 local title III supported legal services programs, compared with approximately 100 programs in July 1976. The numbers of older persons receiving title III funded legal services increased from 200,000 in fiscal year 1977 to 400,000 persons in fiscal year 1980.

During fiscal year 1980 the three biregional support centers then in existence conducted planning events in 32 States, convened two training conferences for about 60 legal services developers and ombudsmen, and held approximately 90 training events for both trainers and advocates. In addition, staff members from the centers made visits to the States to participate in planning sessions, conferences, and workshops.

Training packages are now available from the centers on basic advocacy skills, systems building, public benefits representation, nursing home advocacy, legislative advocacy, and long-term care issues. Substantive materials exist on social security, SSI, food stamps, medicaid, housing, consumer, mental health, guardianship, commitment, and other subjects.[8]

B. SERVING THOSE IN NEED

1. Improving Systems and Services

In this area, AoA supports projects designated to foster the continued development of systems and services, to improve community based services, to strengthen family support activities, to reach out to minorities, to address the unique needs of special target populations, and to provide relief to older persons who are victims of natural disasters.

A description of activities carried out with discretionary resources intended to provide knowledge supporting the continued development of improved systems and services follows. Included are discussions of efforts to strengthen information systems and reporting, and to solve special system problems.

Information Systems and Reporting

State and area agencies represent a unique social experiment in service delivery built on the principles of local responsibility, coordination of multiple public and private resources, and public-private partnership in the management and provision of services. Developing accurate information about State and area agency systems and services is necessary to provide policymakers with the capacity to evaluate the effectiveness of public funding commitments and to permit national judgments about ways to improve and enhance services to older people. Unique problems exist in developing such information in view of the degree of flexibility given to State and area agencies and the mix of public-private management of resources. The AoA objective is to develop information usable by local and State policymakers while also providing data necessary for national policymaking and for accountability to the Congress and, at the same time, limiting paperwork requirements.

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[8] Total $5 million appropriated under section 451 reserved for legal services or to facilitate the provision of legal service through: Advocacy assistance grants, $1,893,000; biregional advocacy support centers for advocacy assistance, $2,427,000; additional legal service support, $707,000.

A detailed listing of projects under this category is contained in appendix VIII. The $5 million resource commitment represents only fiscal year 1980 amounts.

A joint advisory body of State and area agency personnel under the auspices of AoA, National Association of State Units on Aging (NASUA) and National Association of Area Agencies on Aging (N4A) has been: (1) Advising AoA on modifying formal reporting requirements; (2) developing a taxonomy for service definitions; (3) advising NASUA on an AoA-funded project to codify and disseminate model information systems to State and area agencies; (4) advising AoA on the implementation of ongoing joint Federal-State area agency assessment activities; and (5) advising the GAO on the conduct of a national survey of State and area agencies.

Previously, AoA provided funds to NASUA and N4A to develop and disseminate model information system designs to State and area agencies. Subsequently in 1980, AoA competitively awarded one year information system development grants to five agencies (four State, one area) in Texas, New York, Connecticut, Ohio, and Alabama. Each agency will utilize the NASUA models to develop operational systems. AoA also has awarded funds to the University of Illinois and to the Assistance Group in Silver Spring, Md., to further develop data base information and to assist AoA in the development of State and area plan formats and self-assessment instruments.

Solving Special System Problems

AoA has funded four research projects designed to provide data on special system problems facing State and area agencies. The first, at Portland State University, examines techniques for intervening with community and neighborhood systems to improve services for older people. The second examines models for targeting resources in specific service areas. The third, conducted by the University of California, examines the impact of the decentralized structure of State and area agencies on funding patterns, service priorities, and performance standards or criteria employed by State agencies. The fourth project studies the effectiveness of neighborhood and community organizations in developing effective self-help programs.

2. Improving Community Based Services

The community based services authorized in title III of the Older Americans Act are classified in four categories: Activities which improve access to services; community and neighborhood services; in-home services, and services to residents of care providing facilities. Discretionary activities to strengthen and improve services in each category are discussed below.

Improving Access to Services

Access involves the development of services and community systems of varying degrees of complexity to provide information to clients, to assess their individual needs, and to counsel, refer, and directly assist individuals in obtaining services including escort and transportation. AoA uses discretionary resources to develop models and knowledge which can be evaluated and made available to State and Area agencies to improve the operation of access services nationwide.

AoA is supporting three research projects to study case management. One of particular interest, in Louisville, Ky., will develop a model to increase the client's ability to exercise choice in selecting services and service providers. A second, conducted by the University of Pennsylvania, seeks to develop information on assisting older people in emergency and crisis situations. A third at the University of Southern California is conducting an inventory of case management and coordination programs for the aging.

AoA-sponsored model projects include the use of a community voluntary board to monitor services. Another at the Miami Jewish Home and Hospital is utilizing a multidisciplinary team to assure access to a full continuum of services.

Three research projects are examining ways to improve the effectiveness of transportation services.

Community and Neighborhood Services

Older people are dependent on the neighborhood and the community for meeting basic needs. Studies are being conducted to estimate the number and characteristics of special retirement communities. A study by the National Center for Black Aged is examining problems of older people in neighborhoods undergoing revitalization.

The National Council on Aging is developing models for senior centers. The Waxter Center in Baltimore is developing a model for providing services for the disabled at senior centers. Similar projects are being supported by AoA at the Jamaica Service Center in New York. The Northern Kentucky Mental Health Mental Retardation Board is operating an experimental day care center program for older people who are "at risk" of institutionalization.

Older people consistently report problems in securing adequate health care services. Area agencies report that needing assistance with health care services is one of the most frequent requests of older people who use information and referral services. In addition to the nationwide annual promotion of community health fairs initiated by AoA in 1978, and the national-impact primary health care demonstrations conducted by AoA and the Health Services Administration, (described elsewhere), research and model projects related to these services are being implemented in six locations around the country. Among these is a very promising project encouraging health promotion conducted by the University of Washington at the Wallingford Senior Center in Seattle for persons over 75. In another project the American Dietetic Association is studying food service technologies for AoA. In still another project Temple University is studying and reviewing the national policy implications of a seres of AoA-supported community service demonstrations and will prepare the results for disseminaton to State and area agencies.

In-Home Services

Two research studies to examine and improve in-home care are being supported in conjunction with the departmentwide long-term care program. Brandeis University is examining several issues in home care, including how well care planning is done, whom providers select, and the cost of services provided. The Benjamin Rose Institute is studying the effects on families of providing care for older people in residence.

Services to Residents of Care Providing Facilities

AoA is supporting a number of efforts to expand the supply and improve the services available to older people residing in such facilities. Among them is the rural congregate housing initiative.

Under an agreement between the Administration on Aging and the Farmers Home Administration (FmHA), both agencies have been collaborating to enhance the quality of housing and care for older persons living in rural areas. The primary focus of their effort is the design, development, and implementation of a national cooperative demonstration effort in ten sites across the country. During 1980 the sites were developing model congregate housing projects for older persons, with FmHA funds being used to construct the facilities, and AoA funds being used to assist area agencies on aging to support the service components of those facilities. Over the 3-year demonstration period (fiscal years 1980–82), FmHA has targeted $10 million to the project and AoA $2.55 million.

The demonstration sites include Clairborne County, Miss.; Lake County, Mich.; Charles Mix County, S. Dak.; the Eastern Oregon Development Council; Accomack County, Va.; Rio Grande Council of Governments in New Mexico; the Southern Iowa Council of Governments; Riverside County, Calif.; Carroll County, N.H.; and Chatauqua County, N.Y.

This national demonstration program serves as a catalyst to stimulate awareness and cooperation between the State and local networks of each agency. The long-range goal is for projects similar to the demonstrations to be initiated, developed, and supported by the regular programs administered by FmHA and AoA (e.g., section 515 rural rental housing program and title III of the Older Americans Act) at the local level. The section 515 rural rental housing program supported elderly congregate housing for the first time through the 10 site demonstration program.

FmHA has subsequently revised its regulations for the 515 program to: (1) Include elderly congregate housing projects as a category to be funded as a part of the regular funding patterns of the program; (2) require that all applications for elderly congregate housing reflect the involvement of area agencies on aging in the planning for that project; and (3) require that applications for elderly congregate housing include a package of services similar to the package required for the demonstration grants.

3. Strengthening Services To Support Family Care

Families provide more care at home for the elderly than all publicly and privately supported home care combined. AoA regards the family as *the* primary care and support system. Public and private supports are necessary when needs extend beyond the capacity of the family. Large numbers of older people have no living children. Many older people have living parents.

AoA funded five research and eight model projects on the problems associated with assisting the family as a primary care giver. Research is being conducted on older people as self-help care givers, the use of high school students as care givers, measuring intrafamily transfers, and the impact of formal organizations on family networks. A study is being conducted to synthesize and analyze current literature and data for AoA.

The eight model projects include a project to develop and disseminate a training module directed at assisting adult children to be better care givers. Others design and test peer support systems and the use of multidisciplinary teams to strengthen efforts of families and friends in both urban and rural areas.

4. Reaching Out to Minorities

AoA has initiated a major effort to improve services to minorities. The minority elderly population groups are expanding faster than the general population of older people. They experience problems which are different in kind and in degree from the general population.

Lack of familiarity with minority groups' languages and customs can lead to the provision of inappropriate services patterned after a cultural mode which is both alien and unacceptable to minority group members. Recognition of cultural patterns and sensitivities, as well as hiring of minority staff, are needed to develop more acceptance of area agency services in areas with large concentrations of minority group members. Barriers between providers and clients need to be broken down in communities where services may be viewed with suspicion.

During fiscal year 1980, AoA conducted a national competition to permit a limited number of area agencies to implement special affirmative action programs in an effort to improve services to minorities. Four area agencies competed succesfully. Successful models will then be used by AoA to improve nationwide performance of agencies providing services to older people. In addition AoA is conducting six projects specifically targeted to Hispanics as part of an eight-State Office of Human Development Services initiative.

AoA has also entered into cooperative agreements with four national minority organizations. These organizations work directly with minority communities to provide information about available services under Federal and State benefit programs. They work directly with AoA regional offices to assist States and area agencies to improve services to minority communities. In addition, AoA has awarded six research grants to improve information and knowledge about minority needs and services.

5. Special Populations and Special Problems

AoA has also used its research and model project authorities to develop knowledge and practice models to address a number of special problems and special population groups. Five State or area agencies were awarded model projects to demonstrate improved methods for service delivery in rural areas. A research grant was made to the American Foundation for the Blind to study adaptive techniques to compensate for sensory impairment. A handbook will be produced. Three State and area agencies were awarded funds to develop models for meeting needs of abused older persons. Two awards were made to extend services to migrants and refugees. The Columbus Colony is conducting a demonstration at the Ohio State School for the Deaf. Several community hospice projects for the terminally ill are being supported.

6. *Extending Cooperation in the Public and Private Sectors*

The Older Americans Act authorizes AoA to utilize the resources and capacities of public and private organizations to carry out the purposes of the act. The act also authorizes AoA to extend technical assistance to such agencies seeking to enhance their ability to serve older people. In 1980, AoA extended support to a variety of these organizations. The National Council on the Aging through its affiliate, National Voluntary Organizations for Independent Living for the Aged, is working with more than 200 national private organizations to increase their commitment to older people. NASUA and N4A provide extensive technical assistance to State, area agencies, and their providers. The Western Gerontological Society is working with State and area agencies to improve methods to reach underserved populations. The National Association of Counties and the National Conference of Mayors are providing assistance and support to local public officials. The Urban Elderly Coalition and the United Neighborhood Centers of America are extending assistance and support to urban public and private organizations.

7. *Disaster Relief*

The Disaster Relief Act of 1974 provides an orderly and continuing means of assistance by the Federal Government to State and local governments in carrying out their responsibilities to alleviate the suffering and damage resulting from major disasters—hurricane, tornado, snowstorm, fire—or any other catastrophe. The Older Americans Act authorizes AoA, from its discretionary funds, to reimburse a State for funds that it makes available to area agencies for delivery of social services during a major disaster.

The following States received disaster relief funds during fiscal year 1980: Ohio, Washington, Nebraska, Wisconsin, and Alabama. These funds helped provide needed services to older persons for food, clothing, and shelter during disasters.[9]

C. LONG-TERM CARE—MOVING TOWARD A CONTINUUM OF CARE FOR THE FUNCTIONARY DISABLED

The 1978 amendments to the Older Americans Act gave significant impetus to AoA's role with respect to the vulnerable, chronically incapacitated elderly. In particular, Section 422 empowers the Commissioner to make special grants to support the development of comprehensive coordinated systems of community long-term care for older individuals.

Population characteristics of the elderly make clear why the need for long-term care programs is urgent. It is estimated that between 13 and 18 percent of the noninstitutionalized elderly, or over 4 million persons, are to some degree functionally disabled. In 50 years, over 7 million of the population will be functionally disabled.

AoA defines long-term care as health care, social services or personal care including supervision, treatment, or any sort of simple help with everyday tasks, provided formally or informally on a recurring or continuous basis as needed to functionally impaired individuals. The care is provided in homes or other homelike settings in the community, if possible, or in an institutional setting if that is either the client-preferred or the medically necessary option.

Current public policies and programs do not provide a reasonably comprehensive and coordinated range of community based long-term care services. Instead, we have a mix of laws, policies, programs and agencies which result in serious gaps and overlaps in available services and in client eligibility. We have very high government expenditures for medically-oriented institutional care and very little for large numbers of persons who need less costly social-maintenance care in their own home and community. Last year, Federal expenditures for skilled and intermediate care were double the combined costs for SSI, title XX services, in-home care under titles XVIII and XIX of the Social Security Act, community mental health, special housing constructed by DHUD and Older Americans Act funding.

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[9] AoA devoted the following discretionary resources for the purposes described above: Improving systems and joining public and private sectors, $1,871,000; improving community based services, $4,898,000; stren[illegible]g family support, $1,360,000; reaching out to minorities, $8,751,000; special pop[illegible]ons and special problems, $2,879,000; disaster relief, $162,000.

A detailed listing of projects under this category can be found in appendix IX.

The multidisciplinary centers and the geriatric fellowship programs are intended to intensify staff resources development, intensify and spread technology development, and intensify basic and applied research in long-term care.

1. The Long-Term Care Gerontology Center Program

The concerns which the long-term care gerontology center concept addresses are: Health and medical training and research basically oriented to acute problems in an era in which the incidence of chronic illness and functional impairment are rapidly increasing; fragmented orientation to a problem which required a multidisciplinary and interdisciplinary approach; rapid expansion in services; and long range population projections. AoA perceived a need for a Federal effort to establish a basis for intensifying multidisciplinary staff development and basic and applied research, as well as speeding innovation in the treatment of chronic impairment and functional disabilities. Meeting that need meant establishing an organized, integrated capacity in institutions of higher education, in partnership with Federal agencies, geographically dispersed to serve national developmental needs in long-term care. Discussions with the Health Care Financing Administration, Veterans' Administration, National Institute of Mental Health, Health Services Administration, and Health Resources Administration, as well as with academicians indicated agreement with the concept.

Focusing on a combined health/social services approach, these centers have a defined relationship both with a medical school and with community based long-term care services provider agencies. The four-fold purpose of this major program is:

- —To enhance the education and training of medical and social service professionals and paraprofessionals regarding the long-term care needs of the elderly and the cost expert and appropriate modes of care, treatment, and services, thereby enlarging the capacity of educational institutions to meet our society's present and future long-term care staff resource needs.
- —To increase the amount and quality of practice-oriented and policy-relevant research dealing with long-term care problems.
- —To facilitate innovation and experimentation in long-term care service delivery in an experimental environment; and
- —To disseminate best practice and knowledge through consultation, technical assistance, continuing education and training, and public information.

AoA is funding the program as a 5-year developmental effort to establish up to 12 multidisciplinary LTC academic centers of excellence. AoA and the institutions provide basic core support for establishing the centers. Each center formally joins medical schools, health science schools, social welfare schools and other units in the phased development of a multidisciplinary program under the direction of the center.

Year one (1978) involved program planning and concept development jointly with Federal agencies and the academic community. Year two (1979) executed first-year planning awards to 22 institutions (out of nearly 50 proposals). During year three (1980), five centers were established as operational, four institutions received second year planning awards, and seven institutions received new planning grants. Thirteen institutions funded in 1979 were competitively dropped. Years four and five will develop up to 12 fully operational centers, geographically dispersed.

2. Geriatric Fellowship Program

With rare exception, undergraduate and postgraduate training of today's primary care physicians does not include exposure to and competence in the growing body of knowledge concerning clinical and case management problems that occur frequently with older patients.

In an effort to improve the quality of medical care and to encourage new professionals to enter the field or geriatric medicine, the Administration on Aging is supporting a number of geriatric fellowships which will offer future medical professionals exposure to the special body of knowledge related to geriatric medicine, to the special ethical issues related to the care of older persons, to the social, economic and psychological problems which interact with health problems, and to new approaches to long-term care in the community and/or institutions. These geriatric physicians will then become members of medical school facilities for the purpose of training other geriatric physicians, exposing medical students to geriatric issues, and supervising and encouraging research and practical experiences related to geriatric care.

During fiscal year 1979, the Administration on Aging awarded six grants (which were continued in fiscal year 1980) to support the development of multiyear programs to train 18 future faculty members.

3. National Channeling Demonstration Program

The national channeling demonstration program is a major Departmental initiative aimed at testing the extent to which State and local governments and agencies can develop, coordinate, and manage long-term care services that: (a) Are available and accessible to those persons who need them; (b) are provided in the least restrictive environment, preferably at home or in other community settings; and (c) can be delivered without any substantial amounts of new dollars, by deemphasizing the use of acute care and nursing home facilities. At the core of the channeling concept are the functions of client assessment and case management including monitoring and reassessment as methods for organizing care to meet individual needs and controlling long-term care expenditures. It is a departure from current general practice because it includes both client-focused services and an altered set of relationships among health, mental health, and social services agencies which help clients gain access to a wider array of services than is usually available.

Twelve States received 2-year contract awards in fiscal year 1980 to develop and carry out the channeling demonstrations. Accompanying the channeling demonstrations is an evaluation contract to measure the effects, benefits, and costs of the channeling projects, and a technical assistance contract to inform, advise, train, and otherwise help the channeling projects in their work. Eight projects were competitively awarded to State agencies on aging. Twenty-two of the 28 sites are either area agencies or were jointly selected by State and area agencies. AoA and the Health Care Financing Administration (HCFA) jointly share in funding this Departmental initiative, which is being coordinated by the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

4. State System Development

Another component in the channeling demonstration program is State system development. In 1980, State system development grants were given to 15 States. Under these grants the States will identify the long-term care needs of the population with emphasis on the elderly, survey the available services, and analyze barriers which restrict the establishment of an effective statewide long-term care system. The States will plan such a system and submit the plan to HHS with recommendations for legislative and administrative changes needed at all levels of government for implementation.

5. State and Community Model Building

Another objective of AoA's long-term care activities is to conduct model projects to promote and develop community based planning and service capacities to meet the needs of chronically ill and functionally impaired older people. The AoA/Health Services Administration demonstration projects utilize primary health care facilities as model service delivery points for vulnerable older persons. The long-term care model projects demonstrate the effectiveness of special services ranging from a continuum of care.

AoA/Health Services Administration Demonstration Projects

The AoA/HSA demonstration projects represent a joint effort aimed at the effective use of primary health care facilities and services by vulnerable older persons. A corollary objective is to coordinate existing social and health services delivery systems through the AoA and HSA networks. In order to implement this program AoA and HSA developed a memorandum of understanding to improve the health and social services systems for older persons through each agency's respective network.

Activities under the memorandum of understanding commenced with funding in fiscal year 1979 by AoA of five awards to community health care clinics and three awards to Indian tribal organizations supported and served by HSA through two of its bureau, the Bureau of Community Health Services and the Indian Health Service. Three new awards to Public Health Service hospitals were made in fiscal year 1980.

Long-Term Care Model Projects

The objective of these projects is to demonstrate how appropriate services can be made available to chronically ill or impaired older persons along a continuum of care. Past experience documents that persons with varying degrees of functional impairment may be found in each of a wide range of settings including their own homes, public housing projects, mental hospitals, acute care hospitals, and nursing homes. In most cases, placement is determined by eligibility and reimbursement provisions of categorical programs. Though many of the impaired elderly need only help with everyday living functions, medicare and medicaid do not pay for such services unless they are provided in conjunction with medical treatment.

Grants support demonstrations testing: Technological advances such as electronically controlled surveillances and reaction systems; innovative methods in developing and providing shelter and supportive personal services at the community level: emergency and respite services to informal support systems; and the ability to monitor the suitability of placement for the older person. Several have subsequently received waivers of medicaid funding restrictions and will measure the impact of decategorized funding on utilization, quality, and cost of services.

Ten model projects were funded in 1980. The grants were awarded to community organizations and area agencies on aging.

6. *Long-Term Care Policy Formulation and Information Exchange*

This AoA effort involves two projects. The first was a national policy conference grant to the University of Chicago School of Social Service Administration as lead agency in an informal consortium of academic institutions to conduct an analysis of policy options for improving the provisions of long-term care to the elderly. Papers on six selected topics along with an integrating overview paper were prepared and thoroughly reviewed by panels of specialized experts. These papers were distributed in May, 1980, to about 50 invitees to a 2-day symposium held in June, for which the papers provided a common basis and framework for discussion. The papers have been made available to the Department and are being prepared for publication.

The second project is based upon a cooperative agreement with the National Conference on Social Welfare and its subcontractor, the University of Chicago Center for the Study of Welfare Policy. The major purpose of this effort is to develop and disseminate existing and emerging knowledge about long-term care and related policy issues to designated target audiences including State legislators, program administrators, and other policymakers. The project will disseminate the Chicago Symposium papers and other recent reports through presentation at regional conferences.

7. *Long-Term Care Data Base*

AoA is an active participant in a Departmental effort to develop a comprehensive data base for future long-term care policy decisionmaking. Two key projects were begun in fiscal year 1980 as part of a Departmental statistical plan for nationally representative long-term care data. One contract award was for the analysis and assessment of existing data on various important aspects of long-term care. The second contract award was for the development of methodology to conduct two future national surveys: a survey of impaired individuals in households and a survey of individuals in institutions. These projects are funded by HCFA.[10]

D. IMPROVING CAPACITY THROUGH APPLICATION OF KNOWLEDGE

The development of health and social services for older people parallels the increase in the older population. The ability of families, community agencies, and State and area agencies to care for older persons is affected by the degree of skill and competence of personnel. It is also affected by the use of new technologies and practice techniques. A primary objective of AoA is to improve the knowledge and skills of policymakers, administrators, and service providers and to provide them with improved techniques for developing and managing services.

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[10] AoA devoted the following discretionary resources to the purposes related to long-term care described above: Long-term care gerontology centers, $4,023,000; geriatric fellowships, $585,000; channeling demonstrations, $8,550,000; State system development, $1,769,000; State and community model building, $2,572,000; policy formulation and information exchange, $338,000.

A detailed listing of the projects under this category can be found in appendix X.

Utilization involves the development of knowledge through research, aggregating and organizing information for systematic distribution and dissemination, preparing users through training, technical assistance and applied demonstrations to use knowledge, and ultimately incorporating knowledge in policy articulation, program implementation, and practice.

1. Career Preparation

The title IV–A gerontology career preparation program is designed to support the training of persons who are employed or preparing for employment in the field of aging. AoA is committed to building the capacity of institutions of higher education to prepare persons for careers in aging and to retrain other persons already working with older people.

Priorities in 1980 were: (1) Policy formulation, planning, and management; (2) case management or services management; (3) administration of services including health, mental health, legal services, employment guidance and counseling, services delivered in congregate housing and community focal points, home care, day care, protective services, or transportation; and (4) administration of services to special populations such as minority groups, the rural elderly, the inner cities elderly, or the developmentally disabled.

AoA funds universitywide projects, graduate and professional school projects, 2- and 4-year undergraduate projects, and consortia projects. In 1980, 80 institutions received support under the career preparation program. A study conducted for AoA by Ketron, Inc., indicated that courses are being offered in over 200 degree programs across a wide variety of disciplines. Over 14,000 students were enrolled in courses on aging. Over 3,100 students received degrees with a concentration in aging and another 1,100 completed full degree programs in aging. Only 1,400 students received financial assistance. Almost 95 percent of those specializing in or receiving degrees in aging were employed within 1 year of graduation. Sixty percent of those concentrating in aging and 82 percent of the degree holders were working in aging-related jobs. More than 20 minority institutions received support in 1980.

2. Enhancing Careers in Aging for Minorities

The minority research associate program was initiated in response to the 1978 amendments to the Older Americans Act. In addition to increasing support for minority institutions under the career preparation program, AoA implemented this program to strengthen the participation of minority scholars in the field of aging research.

Five projects were funded with institutions or organizations with sufficient program resources to effectively recruit qualified minority social scientists and to foster research activity focused on expansion of knowledge concerning the needs of racial and ethnic minority elderly—Asian/Pacific Americans, blacks, Hispanics, and Native Americans—and the improvement of services to meet such needs.

3. Development of Continuing Education Material and Technical Assistance

The national continuing education and training program strategically focuses limited resources on continuing education systems in an effort to assist in the redesign of curricula and approaches to delivery of education and training for personnel working with older people. Continuing education and technical assistance programs have two interrelated objectives. Simultaneously, projects develop specific curricula for introduction into the continuing education programs of higher educational institutions and provide direct training of personnel working in the aging network. Contracts or grants are awarded competitively for the development and field testing of training and technical assistance materials.

Once developed, tested, and adopted for use by AoA, packages are distributed to educational institutions, regional offices and State agencies. Depending on the scope and scale of the dissemination task, AoA awards a supplemental grant to the originating grantee to train regional office and State agency personnel in the use of the package or it is turned over to the regional education and training program (described below) to conduct multiple State and area agency training workshops.

The primary targets of continuing education and technical assistance efforts are individuals employed in programs administered under the act. The dual approach also institutionalizes the use of educational curricula in ongoing continuing education programs, thereby reaching other professionals and practitioners.

In 1980, AoA supported 22 continuing education and technical assistance grants and contracts. Projects span the services systems of State and Area agencies. NASUA has designed model information system development guides and is now extending technical assistance to State and area agency personnel. Miami-Dade Community College is developing curricula on serving minorities. A technical assistance contract has been awarded to improve fiscal management activities for State and area agencies. Assistance is being provided to 85 Indian tribes receiving support under title VI. Other projects are in the areas of long-term care systems, in-home services, senior centers, housing, health promotion, and counseling.

4. Marshaling Resources To Support Operational Programs—The Regional Education and Training Program

The primary goal of the regional education and training program is to foster, on a regional basis, a more holistic, coordinated approach to education and training by promoting greater understanding and linkages among higher education institutions, State and area agencies on aging, and service providers. Pursuing such an approach will result, over time, in more strategic uses of limited education and training resources, both those available under the Older Americans Act and those from other sources. Under this program regional offices:

—Convene regular regional conferences to bring together representatives from higher education institutions, State and area agencies and service providers to discuss common education and training problems and opportunities.

—Convene regional research utilization and dissemination conferences around subject matter areas of common interest to academics and practitioners using results of ongoing research and demonstration projects.

—Promote and assist with the pooling of education and training resources to meet common interstate needs.

—Prepare, in cooperation with the State agencies on aging, regional education and training needs assessments of current personnel in the field, starting with State and area agency staff and local service providers.

—Prepare inventories of all education and training resources available in the region and develop strategies for better utilizing these resources.

—Examine the need for and, as appropriate, develop employment or placement services programs for gerontology students and graduates and practitioner personnel seeking jobs in the region.

—Act as a regional clearinghouse for gathering and disseminating educational, training, and technical assistance materials; and

—Assist in the planning for national, biregional, and regional training, technical assistance, and continuing education efforts.

To help implement this new program, contractual assistance has been made available to each regional office. The purpose of these 10 procurements is to assist in institutionalizing the regional education and training program over a multiyear developmental period.

5. Improving Skills of State, Area and Service Personnel

State agencies were awarded support in 1980 for the following training activities:

—In-service training to upgrade the job knowledge and skills of State and area agency on aging staffs and service provider personnel.

—Staff development programs to improve performance and career opportunities; and

—Planning, resource development, and administrative undertakings designed to promote consortia building.

6. Dissemination and Utilization

The need for a highly visible and effective information system in the field of aging has been intensifying for some time. Over 5,000 new publications on gerontology are issued each year. The rapidly rising demand for information from those working within and outside the national network on aging has created a need for systematic dissemination and utilization of information. A mechanism for bibliographic literature control and timely access to the information contained in the literature is essential if the field of aging is to continue to mature. For example, AoA has developed a dissemination and utilization strategy aimed at both the broad base of gerontological literature and those products and reports funded by AoA's discretionary programs.

7. *National Clearinghouse and Service Center for Aging Information (SCAN)*

SCAN is a national bibliographic information system which is designed to be an active rather than a passive system. To make its clientele aware of what is available for use and encourage use, several current mechanisms and an aggressive marketing strategy are part of the system. Current awareness will be highlighted by a monthly abstract journal and newsletter. Marketing will include user workshops at professional conferences and a system of approximately 240 repository libraries to provide access and assistance to the community level.

Two resource centers are planned for implementation of the SCAN system and each will be organized along disciplinary lines covering the broad topic areas of social gerontology (funded in 1980), and biomedical sciences (to be funded in 1981). The functions of each resource center will be to process (acquire/select, index, and abstract) literature in its assigned subject area, to provide user services, and to prepare special publications. Each resource center will identify a wide spectrum of literature pertaining to its topic area. Each center will collect English language journal and document literature. The literature to be collected will include not only the fundamental research literature, but dissertations, books, monographs, conference papers, and special reports.

The social gerontology resources center will also collect information about projects which can be determined to be innovative or suitable as a model for replication elsewhere. This function is known as the program experience exchange. The resource center will use an advisory board to review projects for selection into the file. The resource center also provides access to a file of institutional and training materials organized by subject. The advisory board will consider such factors as innovativeness of programs, best practice, and representation of all program areas during the selection process.

As of fiscal year 1980, the social gerontology resource center has acquired and abstracted approximately 4,000 new documents and journal articles, completed 100 special bibliographies, and six technical publications. The bibliographies, when organized under major topic areas, and the reports will be disseminated to the network of State and area agencies on aging for their use. Requests from individuals for bibliographic and information services are received at rate of 200 per month. The SCAN information system has been exhibited, and/or symposia held, at five major conferences during the past 18 months.

During fiscal year 1980, staff of the clearinghouse also responded to over 3,500 inquiries which required individual written replies, distributed over 700,000 publications based on requests of single and multiple copies, responded to 18,000 telephone requests for information, and provided services to 2,000 visitors.

National Data Archive

AoA and the National Institute on Aging are supporting a national data archive at the University of Michigan through the Institute of Gerontology and the Institute for Social Research. The archive collects, codifies and stores original data base information in a diverse array of areas. The archive project provides ready access, training and technical assistance in using the data for secondary analysis to over 270 academic institutions as well as aging network personnel.

Gerontological Research Institute

AoA has funded the Gerontological Research Institute to develop an agency utilization strategy. The GRI has studied past utilization of AoA projects to provide insights for future strategy building. At the request of AoA, the GRI will prepare for general dissemination research synthesis reports aggregating findings of several research products in defined areas.[11]

E. "GRANTS FOR INDIAN TRIBES"—TITLE VI OF THE OLDER AMERICANS ACT

At the end of fiscal year 1980, AoA awarded title VI grants totaling $6 million to 85 Indian tribal organizations. These awards were the first to be issued under the authority of title VI. (There was no funding for title VI in fiscal year 1979.) The grants were made in accordance with the title VI regulations issued July 18, 1980.[12]

The purpose of the new program for tribal organizations is to promote the delivery of needed social and nutrition services to Indians aged 60 and over. While funds for services for older Indians have always been available through State and area agencies under the Older Americans Act, the new title allows Indian organizations to apply for direct Federal funding. This method of funding is consistent with the policy of self-determination for Indian tribes. Tribal organizations may receive funds through State and area agencies under title III directly from AoA under title VI, as long as each funding source is used to serve different individuals. In addition to social services, such as legal services, nutrition and information and referral, title VI funds may be used for acquiring, altering or renovating multipurpose senior centers for Indians.

Although the minimum age for Indians participating in title VI programs is set at 60 years, spouses of any age may participate in nutrition services.

Applications for grant awards were accepted from those tribal organizations that established their eligibility through a preapplication process.

F. EVALUATION

During fiscal year 1980, AoA had no evaluation studies scheduled for completion. However, the following is a brief report on the progress of current evaluation activities:

—*Longitudinal evaluation of the national nutrition program for the elderly:* Work on a new sample design for the collection of wave II data for this study has been completed. The package containing the new sample design and revised data collection instruments is ready for submission to the Office of Management and Budget.

—*Analyses of food service delivery systems used in providing nutrition services to the elderly:* The contractor responsible for this study has recently completed a telephone survey of 1,155 nutrition projects and has exhaustively analyzed the data through an interim report. Data collection for the full-time length study is expected to be completed by the end of March 1981 which will be followed by a final report containing data analysis around July 1981.

—*Evaluation of differences in needs and service programs between the rural and urban elderly:* AoA is in the process of preparing an interim report based on secondary data sources relating to this study mandated by the Congress. AoA expects to transmit this report to the Congress during the early part of 1981.

—*The evaluation of advocacy programs funded under title III of the Older Americans Act:* This study, mandated by the Congress, is nearing the stage of completion. AoA plans to transmit the report on legal services to the Congress during the early part of 1981. A more comprehensive, technical report will become available in March 1981.

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[11] AoA devoted the following discretionary resources to the purposes described above related to improving capacity: Career preparation, $7,906,000; enhancing careers for minorities, $297,000; development of continuing education materials and technical assistance, $2,351,000; marshaling resources, $1,635,000; improving skills of personnel, $1,938,000; dissemination and utilization, $643,000.

A detailed listing of projects under this category can be found in appendix XI.

[12] A region-by-region summary of title VI grants may be found in appendix XII. A more detailed listing of grantees may be found in appendix IX.

APPENDIX I

FY 1980 BUDGET

ADMINISTRATION ON AGING

State and Area Agency Activities 1/	$ 22,500.000
Social Services & Senior Centers 1/	246.970.000
Nutrition Services 1/	
Congregate Nutrition Services	270,000.000
Home Delivered Nutrition Services	50,000,000
Subtotal	320.000.000
Grants to Indian Tribes	6,000,000
Training Research & Discretionary Projects and Programs	
Training	17.000,000
Research	8,500.000
Discretionary Projects & Programs	25,000,000
Multidisciplinary Centers	3,800,000
Subtotal	54,300,000
Federal Council on Aging	450,000
National Clearinghouse on Aging	2.000.000
TOTAL	652,220,000

1/ Up to 8.5% of the funds for Social Services and Senior Centers and Nutrition Services may be used for Area Agency Activities.

FY 1980 - State allotment amounts under Title III-B, Social Services of the Older Americans Act of 1965, as amended, after reallotment (Available for obligation through September 30, 1980 - Reallotted amounts must be obligated by September 30, 1981). Amounts do not reflect transfers.

APPENDIX II

13.633 57 States	Allotment FY-80-2	Amount Reallotted	Amount Released	Final Allotment After Reallotment
TOTALS	$264,500,300	680,455	(200,455)	264,980,300
Alabama	3,922,708	16,813		3,939,521
Alaska	1,222,501	5,000		1,227,501
Arizona	2,559,887	1/ 10,972		2,570,859
Arkansas	2,731,743	11,709		2,743,452
California	22,094,560			22,094,560
Colorado	2,283,354	9,787		2,293,141
Connecticut	3,644,095	14,762		3,658,857
Delaware	1,222,501			1,222,501
Dist of Col	1,222,501	5,000		1,227,501
Florida	13,556,573			13,556,573
Georgia	4,582,728	19,642		4,602,370
Hawaii	1,222,501			1,222,501
Idaho	1,222,501	5,000		1,227,501
Illinois	11,798,423			11,798,423
Indiana	5,612,319	23,284		5,635,603
Iowa	3,535,264			3,535,264
Kansas	2,783,610	11,931		2,795,541
Kentucky	3,714,388	15,920		3,730,308
Louisiana	3,590,066			3,590,066
Maine	1,263,051	5,614		1,268,665
Maryland	3,731,311			3,731,311
Massachusetts	6,726,878	28,832		6,755,710
Michigan	8,552,513	36,657		8,589,170
Minnesota	4,345,957	18,627		4,364,626
Mississippi	2,498,420			2,498,420
Missouri	5,838,470			5,838,470
Montana	1,222,501	5,000		1,227,501
Nebraska	1,865,742			1,865,742
Nevada	1,222,501	5,000		1,227,501
New Hampshire	1,222,501			1,222,501
New Jersey	8,183,013	35,073		8,218,086
New Mexico	1,222,501	1/ 5,000		1,227,501
New York	20,361,813	87,273		20,449,086
North Carolina	5,389,394			5,389,394
North Dakota	1,222,501			1,222,501
Ohio	10,978,222	47,054		11,025,276
Oklahoma	3,348,442	14,352		3,362,794
Oregon	2,768,595	11,867		2,780,462
Pennsylvania	14,347,995	61,497		14,409,492
Rhode Island	1,222,501			1,222,501
South Carolina	2,553,660	10,966		2,564,626
South Dakota	1,222,501			1,222,501
Tennessee	4,603,969	19,733		4,623,702
Texas	12,186,922	52,235		12,239,157
Utah	1,222,501	1/ 5,000		1,222,501
Vermont	1,222,501			1,222,501
Virginia	4,680,943	20,063		4,701,006
Washington	3,859,416	16,542		3,875,958
West Virginia	2,190,981	9,401		2,200,382
Wisconsin	5,207,549	22,320		5,229,869
Wyoming	1,222,501			1,222,501
American Samoa	152,813	2/		152,813
Guam	611,251	1,000		612,251
Puerto Rico	2,510,582	10,761		2,521,343
Trust Territory	611,251		(200,455)	410,796
Virgin Islands	611,251			611,251
N.Mariana Is.	152,813	1,000		153,813

1/ Amounts adjusted on Statement of Grant Award to represent transfers to Interstate Planning and Service Areas in Arizona, New Mexico and Utah. See Grant Award.

2/ Additional funds have been awarded to American Samoa in order to provide funding at the FY 1978 level. These additional funds have been withheld from the amount reserved for evaluation. See Grant Award $325,862.

3/ $200,455 released for reallotment. $680,000 reallotted from amount originally earmarked for evaluation.

Administration on Aging, OHD
Office of Health and Human Services

[illegible] Allotment Amounts [illegible] Title I, [illegible] 1965, as amended, after Reallotment (available for obligation through September 30, 1980 - Reallotted amounts must be obligated by September 30, 1981); amounts do not reflect transfers

APPENDIX II (cont)

57 States	Allotment FY-80-	Amount Reallotted	Amount Released	Final Allotment After Reallotment
TOTALS	$267,300,000	$503,844	(503,844)	267,300,000
Alabama	4,288,501	12,670		4,301,171
Alaska	1,336,500			1,336,500
Arizona	2,798,597	1/ 8,268		2,806,865
Arkansas	2,986,479	8,823		2995,302
California	24,154,879			24,154,879
Colorado	2,496,277	7,375		2503,652
Connecticut	3,765,258	11,124		3,776,382
Delaware	1,336,500			1,336,500
Dist. of Col.	1,336,500	5,000		1,341,500
Florida	14,820,726			14,820,726
Georgia	5,010,068	14,801		5024,869
Hawaii	1,336,500			1,336,500
Idaho	1,336,500	5,000		1,341,500
Illinois	12,898,628			12,898,628
Indiana	5,938,886			5,938,886
Iowa	3,864,928	11,418		3,876,346
Kansas	3,043,182	8,991		3,052,173
Kentucky	4,060,755	11,997		4,072,752
Louisiana	3,926,818			3,926,818
Maine	1,380,831	5,000		1,385,831
Maryland	4,079,257			4,079,257
Massachusetts	7,354,161	21,226		7375,387
Michigan	8,350,036	22,622		8372,658
Minnesota	4,751,262	14,037		4765,299
Mississippi	2,731,388	8,060		2739,448
Missouri	6,382,909			6,382,909
Montana	1,336,500	5,000		1,341,500
Nebraska	2,019,723			2,019,723
Nevada	1,336,500	5,000		1,341,500
New Hampshire	1,336,500			1,336,500
New Jersey	8,946,080	26,430		8,972,510
New Mexico	1,336,500	1/ 5,000		1,341,500
New York	22,260,556	65,765		22,326,321
North Carolina	5,891,955			5,891,955
North Dakota	1,336,500			1,336,500
Ohio	12,001,943	35,458		12,037,401
Oklahoma	3,660,685	10,815		3,671,500
Oregon	3,026,767	8,942		3,035,709
Pennsylvania	15,685,948	46,341		15,732,289
Rhode Island	1,336,500	5,000		1,341,500
South Carolina	2,791,592	8,247		2,799,839
South Dakota	1,336,500	5,000		1,341,500
Tennessee	5,033,290	14,870		5,048,160
Texas	13,323,154	39,161		13,362,315
Utah	1,336,500 1/	5,000		1,341,500
Vermont	1,336,500			1,336,500
Virginia	5,117,441	15,119		5,132,560
Washington	6,219,307	12,465		6,231,772
West Virginia	2,395,301			2,395,301
Wisconsin	5,693,153			5,693,153
Wyoming	1,336,500			1,336,500
American Samoa	167,063 2/			167,063
Guam	968,250			968,250
Puerto Rico	2,744,694	8,109		2,752,803
Trust Territory	968,250		(503,844) 3/	464,406
Virgin Islands	968,250			968,250
N. Mar. Islands	167,063			167,063

1/ Amounts adjusted on Statement of Grant Award to represent transfers to Interstate Planning and Services areas in Arizona, New Mexico and Utah. See grant award.

2/ Additional funds have been awarded to Americans Samoa in order to provide funding at the FY 1980 level. These additional funds have been withheld from the amount reserved for evaluation. See grant award $620,750.

3/ $503,844 released for reallotment.

October 1980

[illegible]

FY 1980 - State Allotments under Title III-C-2- Home Delivered Meals, Older Americans Act of 1965, as amended, after Reallotment (Available for obligation through September 30, 1980 - Reallotted amounts must be obligated by September 30, 1981). Amounts do not reflect transfers.

APPENDIX II (cont)

13.633 57 States	Allotment PI-80-2	Amount Reallotted	Amount Released	Final Allotment After Reallotment
TOTALS	$49,500,000	100,702	(100,702)	49,500,000
Alabama	794,167	2,500		796,667
Alaska	247,500	2,500		250,000
Arizona	518,259	1/2,500		520,759
Arkansas	553,052	2,500		555,552
California	4,473,126			4,473,126
Colorado	662,273	2,500		664,773
Connecticut	697,270	2,500		699,770
Delaware	247,500			247,500
Dist of Col	247,500			247,500
Florida	2,744,579			2,744,579
Georgia	927,790	2,500		930,290
Hawaii	247,500	2,500		250,000
Idaho	247,500	2,500		250,000
Illinois	2,388,635			2,388,635
Indiana	1,099,793	2,500		1,102,293
Iowa	715,727	2,500		718,227
Kansas	563,552			563,552
Kentucky	751,992	2,500		754,492
Louisiana	726,818			726,818
Maine	255,709			255,709
Maryland	255,418			255,418
Massachusetts	1,361,782	3,093		1,364,875
Michigan	1,731,588	3,833		1,735,421
Minnesota	879,863			879,863
Mississippi	505,815			505,815
Missouri	1,182,020			1,182,020
Montana	247,500	2,500		250,000
Nebraska	377,727			377,727
Nevada	247,500	2,500		250,000
New Hampshire	247,500			247,500
New Jersey	1,656,682	3,763		1,660,445
New Mexico	247,500	1/ 2,500		250,000
New York	4,122,325	9,363		4,131,688
North Carolina	1,091,103			1,091,103
North Dakota	247,500			247,500
Ohio	2,222,582	5,048		2,227,630
Oklahoma	677,905	2,500		680,405
Oregon	560,512	2,500		563,012
Pennsylvania	2,904,805	6,598		2,911,403
Rhode Island	247,500	2,500		250,000
South Carolina	516,962	2,500		519,462
South Dakota	247,500	2,500		250,000
Tennessee	932,091	2,500		934,591
Texas	2,467,288	5,604		2,472,892
Utah	247,500	1/		247,500
Vermont	247,500			247,500
Virginia	947,674	2,500		950,174
Washington	781,353	2,500		783,853
West Virginia	443,574			443,574
Wisconsin	1,054,288	2,500		1,056,788
Wyoming	247,500			247,500
American Samoa	30,937	2/		30,937
Guam	123,750	800		124,550
Puerto Rico	508,277	2,500		510,777
Trust Territory	123,750		(100,702)	23,048
Virgin Islands	123,750			123,750
N.Mariana Is.	30,937			30,937

1/ Amounts adjusted on Statement of Grant Award to represent transfers to and Service Areas in Arizona, New Mexico and Utah. See grant awards.

2/ $100,702 released for reallotment.

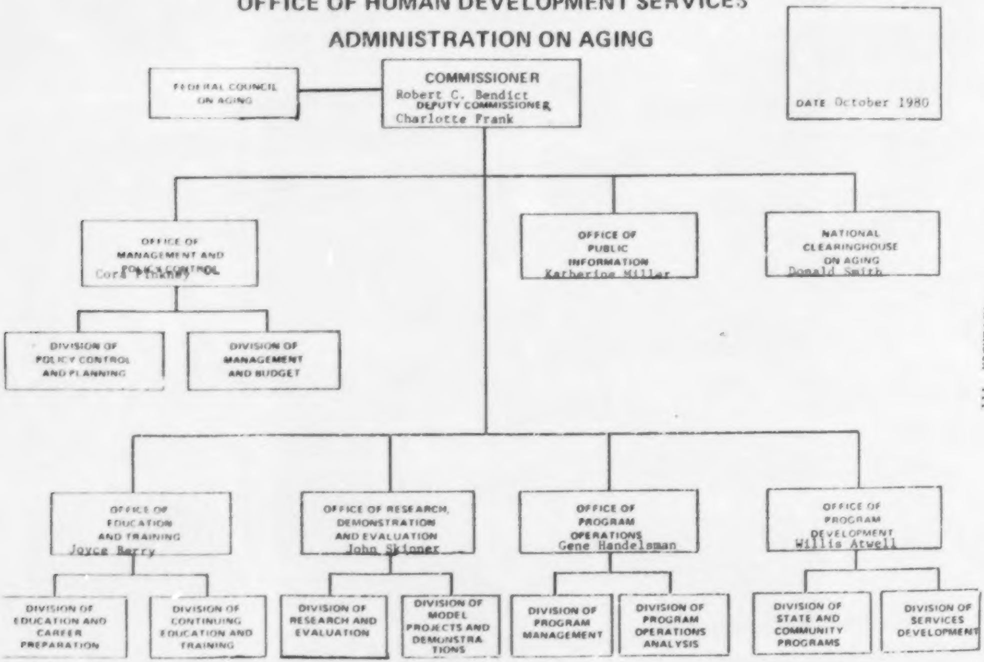
October 1980

Office Health Human Services
Administration on Aging, OHDS

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF HUMAN DEVELOPMENT SERVICES

ADMINISTRATION ON AGING


DATE October 1980
FEDERAL COUNCIL ON AGING
COMMISSIONER
Robert C. Bendict
DEPUTY COMMISSIONER
Charlotte Frank
OFFICE OF MANAGEMENT AND POLICY CONTROL
Cora Pinkney
OFFICE OF PUBLIC INFORMATION
Katherine Miller
NATIONAL CLEARINGHOUSE ON AGING
Donald Smith
DIVISION OF POLICY CONTROL AND PLANNING
DIVISION OF MANAGEMENT AND BUDGET
OFFICE OF EDUCATION AND TRAINING
Joyce Berry
OFFICE OF RESEARCH, DEMONSTRATION AND EVALUATION
John Skinner
OFFICE OF PROGRAM OPERATIONS
Gene Handelsman
OFFICE OF PROGRAM DEVELOPMENT
Willis Atwell
DIVISION OF EDUCATION AND CAREER PREPARATION
DIVISION OF CONTINUING EDUCATION AND TRAINING
DIVISION OF RESEARCH AND EVALUATION
DIVISION OF MODEL PROJECTS AND DEMONSTRATIONS
DIVISION OF PROGRAM MANAGEMENT
DIVISION OF PROGRAM OPERATIONS ANALYSIS
DIVISION OF STATE AND COMMUNITY PROGRAMS
DIVISION OF SERVICES DEVELOPMENT

APPENDIX IV

AoA REGIONAL OFFICE LISTINGS

1 Frank Ollivierre
John F. Kennedy Federal Bldg., Room 2007
Boston, Massachusetts 02203
FTS 223 - 1880
8:30 - 5:00
RI, VT, CONN, Maine, Mass., NH
01
Regional Program Director, AoA
Department of Health and Human Services

2 Judith Rackmill
26 Federal Plaza Room 4149
Broadway and Worth Streets
New York, NY 10007
FTS 264 - 4592
8:30 - 5:00
NJ, NY, Puerto Rico, Virgin Islands
02
Regional Program Director, AoA
Department of Health and Human Services

3 Paul E. Ertel, Jr.
P.O. Box 13716 (3535 Market Street)
Philadelphia, PA 19101
FTS 596 - 6892
8:45 - 5:15
DC, MD, VA, Del. PA, W.Va.
03
Regional Program Director, AoA
Department of Health and Human Services

4 Frank Nicholson
101 Marietta Towers, Suite 901
Atlanta, Georgia 30323
FTS 242 - 2972
8:00 - 4:30
Ala., Fla., Miss., S.C., Tenn., N.C., KY, GA
04
Regional Program Director, AoA
Department of Health and Human Services

5 Marian Miller
300 South Wacker Drive -- 15th Floor
Chicago, Illinois 60606
FTS 353 - 3141
8:15 - 4:15
Ill., Ind., Mich., Minn., Ohio, Wisc.
05
Regional Program Director, AoA
Department of Health and Human Services

6 John Diaz
1200 Main Tower Building, Room 2060
Dallas, Texas 75201
FTS 729 - 2971
8:00 - 4:30
Ark., LA, Okla., NM, Texas
06
Regional Program Director, AoA
Department of Health and Human Services

7 Ann Kennedy, Acting
610 East 12th Street
Kansas City, Missouri 64106
FTS 759 - 2955
8:00 - 4:30
Iowa, Kansas, Missouri, Nebraska
07
Regional Program Director, AoA
Department of Health and Human Services

8 Clint Hess
Federal Office Building, Room 7430
19th and Stout Streets
Denver, Colorado 80202
FTS 327 - 2951
7:15 - 5:00
Colo., Mont., Utah, Wyo., ND, SD
08
Regional Program Director, AoA
Department of Health and Human Services

9 Jack McCarthy
50 United Nations Plaza, Room 443
San Francisco, California 94102
FTS 556 - 6003
8:00 - 4:30
Cal., Nev., Ariz., Hawaii, Guam, TTP, Northern Marianas, Samoa
09
Regional Program Director, AoA
Department of Health and Human Services

10 Chisato "Chazz" Kawabori
Arcade Plaza Bldg --1321 2nd Ave.
Mail Stop 909
Seattle, Washington 98101
FTS 399 - 5341
8:00 - 4:30
Alaska, Idaho, Oregon, Washington
10
Regional Program Director, AoA
Department of Health and Human Services

APPENDIX V

DIRECTORY OF STATE AGENCIES DESIGNATED TO ADMINISTER TITLE III OF THE OLDER AMERICANS ACT OF 1965, AS AMENDED

ALABAMA

*# Commission on Aging Executive Park 2853 Fairlane Drive Bldg., "G" Suite #63 Montgomery, Ala. 36130	Chairman Director	Mr. Jesse T. Todd Mrs. Kay K. Kelly (205) 832-6640

ALASKA

* Department of Health & Social Services Pouch H, OIC Juneau, Alaska 99811	Commissioner	Dr. Helen Beirne
# Office on Aging Department of Health & Social Services Pouch H, OIC Juneau, Alaska 99811	Coordinator	M. D. Plotnick (907) 465-4903/04/05/06

ARIZONA

* Department of Economic Security 1717 West Jefferson Phoenix, Arizona 85007	Director	Mr. Bill Jamieson, Jr. (602) 271-5678
# Aging and Adult Administration 1400 W. Washington Street P. O. Box #6123 Phoenix, Arizona 85007	Administrator	Mr. Michael Slattery (602) 271-4446

ARKANSAS

* Deptment of Human Services 406 National Old Lind Bldg. Little Rock, Arkansas 72201	Director	Mr. David Day
# Office on Aging and Adult Services Dept. of Human Services 1428 Donaghey Bldg., #10315 7th and Main Street Little Rock, Arkansas 72201	Director	Ms. Betty King (501) 371-2441

* Umbrella Agency # State Agency on Aging

CALIFORNIA

* Health & Welfare Agency 926 "J" Street, Rm. 917 Sacramento, Calif. 95811	Director	Mr. Mario Obledo
# Dept. of Aging Health & Welfare Agency 918 "J" Street Sacramento, Calif. 95814	Director	Mrs. Janet J. Levy (916) 322-5290

COLORADO

* Department of Social Services 1575 Sherman Street Denver, Colorado 80203	Exec. Director	Mr. Armando R. Atencio
# Division of Services for the Aging Department of Social Services 1575 Sherman Street Denver, Colorado 80203	Director	Mrs. Dorothy D. Anders (303) 839-2651/2586

CONNECTICUT

*# Department on Aging 80 Washington St., Rm. 312 Hartford, Connecticut 06115	Commissioner	Mrs. Maria J. Shealy (203) 566-3867

DELAWARE

* Department of Health & Social Services Delaware State Hospital 3rd Floor - Administration Bldg. New Castle, Delaware 19720	Acting Secretary	Mr. John L. Sullivan (302) 421-6791
# Division of Aging Department of Health & Social Services Delaware State Hospital 3rd Floor - Administration Bldg. New Castle, Delaware 19720	Director	Ms. Eleanor L. Cain (302) 421-6791

DISTRICT OF COLUMBIA

# Office of Aging Office of the Mayor 1012-14th St., N. W., Suite #1106 Washington, D. C. 20005	Exec. Director	Mr. D. Richard Artis (202) 724-5623

FLORIDA

* Dept. of Health & Rehabilitation Services 1323 Winewood Blvd. Tallahassee, Florida 32301	Secretary	Mr. Emmett S. Roberts (904) 488-2650
# Aging & Adult Services Dept. of Health & Rehabilitation Services 1323 Winewood Blvd. Tallahassee, Florida 32301	Program Staff Director	Mr. James P. Doyle (904) 488-2650

GEORGIA

* Dept. of Human Resources 618 Ponce de Leon Avenue, N. E. Atlanta, Georgia 30308	Commissioner	Dr. W. Douglas Skelton (404) 565-5680
# Office of Aging Dept. of Human Resources 618 Ponce de Leon Avenue, N. E. Atlanta, Georgia 30308	Director	Mr. Troy A. Bledsoe (404) 894-5333

GUAM

* Dept. of Public Health & Social Services Government of Guam P. O. Box 2816 Agana, Guam 96910	Director	Ms. Arlene Santos (9-0, ask for Oakland Overseas Operator (746) 4158/2191/4438
# Office of Aging Social Service Dept. of Public Health Government of Guam P. O. Box 2816 Agana, Guam 96910	Director	Mr. Joaquin Camacho 749-9901 X-324

HAWAII

*#
Executive Office on Aging
Office of the Governor
State of Hawaii
1149 Bethel St., Rm. 307
Honolulu, Hawaii 96813

Chairman Mr. Masaichi Tasaka
Director Mr. Renji Goto
(808) 548-2593

IDAHO

*#
Idaho Office on Aging
Statehouse
Boise, Idaho 83720

Director Ms. Rose Bowman
(208)964-3833
FTS: 8-554-3833

ILLINOIS

*#
Department on Aging
421 East Capitol Ave.
Springfield, Illinois 62706

Director Ms. Peg Blaser
(217) 785-3341

INDIANA

*#
Commission on Aging
and Aged
Graphic Arts Bldg.
215 North Senate Ave.
Indianapolis, Indiana 46202

Chairman Mr. Sidney Levin
Exec. Director Mr. Maurice E. Endwright
(317) 232-1190

IOWA

*#
Commission on Aging
415 West 10th Street
Jewett Bldg.
Des Moines, Iowa 50319

Chairman Mrs. Colleen W. Shaw
Exec. Director Mr. Glenn R. Bowles
(515) 281-5187

KANSAS

*#
Department of Aging
610 West 10th St.
Topeka, Kansas 66612

Secretary Mrs. Barbara J. Sabol
(913) 296-4986

KENTUCKY

* Department for Human Resources Capital Annex, Rm. 201 Frankfort, Kentucky 40601	Secretary	Mr. Leslie C. Dawson
# Center for Aging Services Bureau of Social Services Human Resources Bldg., 5th Flr., West 275 East Main Street Frankfort, Kentucky 40601	Director	Mrs. Fannie B. Dorsey (502 564-6930

LOUISIANA

* Governors Office P. O. Box 44215, Capitol Station Baton Rouge, Louisiana 70804	Secretary	William A. Cherry, M.D.
# Office of Elder Affairs P. O. Box 44282, Capital Station Baton Rouge, Louisiana 70804	Exec. Director	Mr. James L. Stovall (FTS) 8-689-2747

MAINE

* Department of Human Services State House Augusta, Maine 04333	Commissioner	Mr. David E. Smith
# Bureau of Maine's Elderly Dept. of Human Services State House Augusta, Maine 04333	Director	Ms. Patricia Riley (207) 289-2561

MARYLAND

*# Office on Aging State Office Bldg. 301 West Preston St. Baltimore, Maryland 21201	Director	Matthew Tayback, SC.D. (301) 383-5064
	Deputy Director	Mr. Harry F. Walker (301) 383-2100

MASSACHUSETTS

*# Department of Elder Affairs 110 Tremont Street Boston, Mass. 02108	Secretary	Dr. Thomas H.D. Mahoney (617) 727-7750/7751/7752

MICHIGAN

*# Office of Services to the Aging 300 East Michigan P. O. Box 30026 Lansing, Michigan 48909	Director	Mr. Peter Kok (517) 373-8230

MINNESOTA

*# Minnesota Board on Aging 204 Metro Square Bldg. 7th & Robert Street St. Paul, Minnesota 55101	Chairman Exec. Secretary	Mr. Cy Carpenter Mr. Gerald A. Bloedow (612) 296-2544

MISSISSIPPI

*# Council on Aging P. O. Box 5136 Fondren Station 510 George Street Jackson, Mississippi 39216	Exec. Director	Mr. Norman Harris (601) 354-6590

MISSOURI

* Department of Social Services Broadway State Office Bldg. P. O. Box 570 Jefferson City, Missouri 65101	Director	Mr. James S. Walsh
# Office of Aging Department of Social Services Broadway State Office Bldg. P. O. Box #570 Jefferson City, Missouri 65101	Director	Mr. David B. Monson (314) 759-3082

MONTANA

* Department of Social & Rehabilitation Services P. O. Box 1723 Helena, Montana	Director	Mr. Keith L. Colbo
# Aging Services Bureau Department of Social & Rehabilitation Services P. O. Box 4210 Helena, Montana	Chief	Ms. Holly Luck 8-587-5650

NEBRASKA

*# Commission on Aging State House Station 95044 Lincoln, Nebraska 68509	Chairman	Mr. Charles Evans
	Exec. Dir.	Mr. James C. Wiley FTS: 8-967-2307 (402) 471-2307

NEVADA

* Department of Human Resources 505 East King Street Room 600 Carson City, Nevada 89710	Director	Mr. Michael L. Melner
# Division for Aging Services Department of Human Resources 505 East King Street Kinkead Bldg., Rm. 600 Carson City, Nevada 89710	Administrator	Mr. John B. McSweeney (702) 885-4210

NEW HAMPSHIRE

*# Council on Aging P. O. Box #786 14 Depot Street Concord, New Hampshire 03301	Chairman	Mr. Francis T. Malloy
	Director	Mrs. Claira P. Monier (603) 271-2751

NEW JERSEY

*# Division on Aging Dept. of Community Affairs P. O. Box 2768 363 West State Street Trenton, New Jersey 08625	Director	Mr. James J. Pennestri (609) 292-4833

NEW MEXICO

*# State Agency on Aging Chamisa Hill Building 440 St. Michaels Drive Santa Fe, New Mexico 87501	Chairman Director	Mr. Clifford Whiting Mr. Ernesto Ramos (505) 827-2802

NEW YORK

*# Office for the Aging Agency Bldg. #2 Empire State Plaza Albany, New York 12223	Chairman Director	Mr. Robert Popper Mrs. Lou Glasse (518) 474-5731
NEW YORK CITY FIELD OFFICE FYI 2 World Trade Center Rm. 5036 New York, New York	Administrator	Mr. Harold Scher (212) 488-6405

NORTH CAROLINA

* Department of Human Resources Albermarle Bldg. Raleigh, North Carolina 27603	Secretary	Sarah T. Morrow, M.D. (919) 829-4534
# Division of Aging Department of Human Resources 708 Hillsborough St., Suite #200 Raleigh, North Carolina 27603	Assistant Secretary	Mr. Nathan H. Yelton (919) 733-3983

NORTH DAKOTA

* Social Services Board of N. D. State Capitol Bldg. Bismarck, North Dakota 58505	Exec. Director	Mr. T.N. Tangedahl (701) 224-2310
# Aging Services Social Services Board of N. D. State Capitol Bldg. Bismarck, N D. 58505	Supervisor	Mr. Gerald D. Shaw (FTS) 8-783-4011 224-2577

OHIO

*# Commission on Aging 50 West Broad Street, 9th Fl. Columbus, Ohio 43216	Chairman Exec. Director	Mr. A. Donald Campbell Mr. Martin A. Janis (614) 466-5500/5501

OKLAHOMA

* Department of Institutions Social & Rehabilitative Services P. O. Box #25352 Oklahoma City, Oklahoma 73125	Director	Mr. Lloyd E. Rader
# Special Unit on Aging Department of Institutions Social & Rehabilitative Services P. O. Box 25352 Oklahoma City, Oklahoma 73125	Director	Mr. Roy Keen (405) 521-2281

OREGON

* Human Resources Department 318 Public Service Bldg. Salem, Oregon 97310	Director	Mr. Leo T. Hegstrom (503) 378-3035
# Office of Elderly Affairs Human Resources Department 772 Commercial St., S. E. Salem, Oregon 97301	Administrator	Mr. Robert S. Zeigen, Ph.D. (FTS) 530-4728 (503) 378-4728

PENNSYLVANIA

* Department of Public Welfare Health & Welfare Bldg. Harrisburg, Penna. 17120	Secretary	Ms. Helen O'Banon
# Department of Aging Rm. 307 Finance Bldg. Harrisburg, Penna. 17120	Secretary	Mr. Gorham L. Black (717) 783-1550

PUERTO RICO

* Department of Social Services P. O. Box 11398 Santurce, Puerto Rico 00910	Secretary	Hon. Janaro-Collazo-Collazo (809) 273-9834
# Gericulture Commission Dept. of Social Services P. O. Box 11398 Santurce, Puerto Rico 00910	Exec. Director	Ms. Alicia Ramirez Suarez (809) 722-2429 (overseas operator)

RHODE ISLAND

*# Dept. of Elder Affairs 79 Washington Street Providence, Rhode Island 02903	Director	Mrs. Anna M. Tucker (401) 277-2858

SAMOA

*# Territorial Administration on Aging Government of American Samoa Pago Pago, American Samoa 96799	Director	Mr. Tali Maae Phone 9-0 (ask for Oakland overseas operator Samoa 3-2121)

SOUTH CAROLINA

*# Commission on Aging 915 Main Street Columbia, South Carolina 29201	Chairman Exec. Director	Dr. Ernest A. Finney Mr. Harry R. Bryan (803) 758-2576

SOUTH DAKOTA

* Dept. of Social Services Office of the Secretary Richard F. Kneip Bldg. Illinois Street Pierre, South Dakota 57501	Acting Secretary	Mr. Donald D. Foreman (605) 773-3165
# Office of Adult Services and and Aging Division of Human Development Department of Social Services Richard F. Kneip Bldg. Pierre, South Dakota 57501	Administrator	Ms. Sylvia Base (FTS) 588-5500 533-6422

TENNESSEE

*# Commission on Aging 703 Tennessee Buildong 535 Church Street Nashville, Tennessee 37219	Acting Director	Mrs. Emily Wiseman (615) 741-2056

TEXAS

*# Governor's Committee on Aging Capitol Station P. O. Box 12786 Austin, Texas 78711	Coordinator	Mrs. Chris Kyker (512) 475-2717

TRUST TERRITORY OF THE PACIFIC

*# Office of Aging Community Development Division Government of the Trust Territory of the Pacific Islands Saipan, Mariana Islands 96950	Administrator	Ms. Leona Peterson Overseas Operator 9-0/2134

UTAH

* Department of Social Services 221 State Capitol Bldg. Salt Lake City, Utah 84102	Exec. Director	Dr. Tony V. Mitchell
# Division of Aging Dept. of Social Services 150 West North Temple, 3rd Fl. Salt Lake City, Utah 84102	Director	Mr. F. Leon PoVey (FTS) 8-588-5500 (801) 533-6422

VERMONT

* Agency of Human Services 103 South Main Street Waterbury, Vermont 05676	Secretary	Sister Elizabeth Candon (802) 828-2471
# Office on Aging 103 South Main Street Waterbury, Vermont 05676	Director	Ms. Mary Ellen S. Spencer (FTS) 8-832-6501

VIRGINIA

*# Office on Aging 830 East Main St. Suite #950 Richmond, Virginia 23219	Director	Ms. Wilda Ferguson (804) 786-7894

VIRGIN ISLANDS

*# Commission on Aging P. O. Box 539 Charlotte Amalie St. Thomas, Virgin Islands 00801	Exec. Secretary	Mrs. Gloria M. King (809) 774-5884

WASHINGTON

* Dept. of Social & Health Services OB-44 Olympia, Washington 98504	Secretary	Mr. Gerald J. Thompson
# Bureau of Aging Dept. of Social & Health Services OB-43G Olympia, Washington 98504	Director	Mr. Charles Reed (206) 753-2502 FTS. 8-434-2502

WEST VIRGINIA

*# Commission on Aging State Capitol Charleston, West Virginia 25305	Exec. Director	Mr. Raymond H. Leinbach 304-348-3317

WISCONSIN

* Department of Health & Social Services State Office Bldg., Rm. 700 1 West Wilson St. Madison 53703	Secretary	Mr. Donald E. Percy
# Division on Aging Department of Health & Social Services 1 West Wilson St., Rm. 686 Madison 53703	Administrator	Ms. Donna McDowell (608) 266-2536

WYOMING

*# Office on Aging Department of Health & Social Services Hathaway Bldg. 720 W. 18th ST Cheyenne 82002	Manager	Mr. J. Atkins (307) 777-7561 (7986) FTS: 8-328-9561

NORTHERN MARIANA ISLANDS

Dept. of Community & Cultural Affairs Commonwealth of the Northern Mariana Islands Civic Center, Susupe Saipan, Mariana Islands 96950	Administrator	Mr. Edward M. Cabrera

APPENDIX VI

FY 1980 ALLOTMENTS FOR STATE PLAN ADMINISTRATION

	%	$	
Total 57 States	100.0000	$22,500,000	
ALAB	1.66874	300000.	
ALAS	0.05150	300000.	
ARIZ	1.08399	300000.	1/
ARK	1.16210	300000.	
CAL	9.39912	1550256.	
COLO	0.97135	300000.	
CONN	1.46513	300000.	
DEL	0.23022	300000.	
DC	0.29396	300000.	
FLA	5.76703	957327.	
GA	1.04951	323419.	
HAW	0.29376	300000.	
IDA	0.37129	300000.	
ILL	5.01910	833171.	
IND	2.31093	383815.	
IOWA	1.50392	300000.	
KANS	1.18415	300000.	
KY	1.58012	300000.	
LA	1.52722	300000.	
ME	0.53731	300000.	
MD	1.58732	300000.	
MASS	2.06164	475033.	
MICH	3.63823	603954.	
MINN	1.84831	305902.	
MISS	1.06284	300000.	
MO	2.46371	412295.	
MONT	0.34948	300000.	
NEBR	0.79369	300000.	
NEV	0.24797	300000.	
NH	0.39147	300000.	
NJ	3.48109	577861.	
NM	0.43749	300000.	1/
NY	8.55200	1437824.	
NC	2.29267	330684.	
ND	0.32182	300000.	
OHIO	4.67018	775251.	
OKLA	1.42144	300000.	
ORE	1.17777	300000.	
PA	6.10370	1013215.	
RI	0.49344	300000.	
SC	1.08526	300000.	
SD	0.35894	300000.	
TENN	1.95595	325119.	
TEX	5.18437	850405.	
UTAH	0.42455	300000.	1/
VT	0.21852	300000.	
VA	1.99129	330555.	
WASH	1.64181	300000.	
WVA	0.93206	300000.	
WISC	2.21531	357742.	
WYO	0.16057	300000.	
PR	1.06801	300000.	
GUAM	0.03898	75000.	
TTER	0.02139	75000.	
V.IS	0.01303	75000.	
AMER	0.00350	75000.	
N.MA	0.00259	75000.	

1/ Amounts adjusted on Statement of Grant Award to represent transfers to Interstate Planning and Service Areas in Arizona, New Mexico, and Utah

Appendix VII

SOCIAL INTEGRATION OF OLDER PEOPLE - A KEY TO THE 21st CENTURY
NATIONAL POLICY DEVELOPMENT
POLICY CONFERENCES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Illinois Institute of Technology	Nat'l Conf. on Constitutional and Other Legal Issues Relating to the Age Discrimination Act	90-AT-0008	$ 58,039
Legal Research and Services for the Elderly, Inc.	Nat'l Conf. on Abuse of Older Persons	90-AT-0007	55,138
Research Foundation of State University of New York	Health Issues of Older Women: A Projection for the Year 2000	90-AT-0021	20,961
University of Hawaii	Cross Cultural Sensitivity to the Needs of the Asian/Pacific Elderly	90-AT-0018	34,499
American Hospital Association	Role of Community Hospitals in Providing Appropriate Care for Older Person	90-AT-0009	55,578
American Psychological Association	Mini-Conf on Mental Health Needs of the Elderly	90-AT-0022	39,474
University of Nebraska at Omaha	Energy and the Elderly: A Policy Response	90-AT-0028	28,968
International Center for Social Gerontology	Nat'l Conf: Housing the Deinstitutionalized Mentally Ill	90-AT-0019	33,023
National Council of Senior Citizens	Conference Program on Key Issues Affecting the Elderly Poor	90-AT-0029	225,000
International Center for Social Gerontology	Symposium: WHCOA's as Potential Agents for Social Change	90-A-1799	63,921
To Be Awarded in FY 1981	Interagency Symposium on Mental Health and the Elderly (with NIMH		110,000
University of Wisconsin	Conference: Social Security and the Changing Roles of Women	SA-80-5292	4,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Coalition of Hispanic Mental Health and Human Services Organizations	National " Hispanic Blue Print for the 80's " Conference	90-AT-0030	4,000
National Institute of Advanced Studies	Regional White House Conference Support		1,200,000
Urban Elderly Coalition	Provision of Effective Planning, Support and Services for Urban Elderly and Network	90-AM-0004	35,000
Western Gerontological	White House Conf. on Aging Mini Conf: Impact of Changing Demographics on Corporations and National Conf. on Older Women	90-AM-0002	44,996
National Indian Council on Aging	1980 National Indian Conf. on Aging	90-AM-2192	40,000
National Center on Black Aged	National Center on Black Aged 1981 White House Conf. on Aging Mini Conf. Series on Black Aging	90-AM-2197	40,000
Asociacion Nacional Pro Personas Mayores	Mini White House Conf. on Hispanic Aging	90-AM-2196	40,000
Special Services for Group, Inc. (National Pacific Asian Elderly Resource Center)	Pacific Asian Mini Conf.	90-AM-2199	40,000
National Interfaith Coalition on Aging	National Symposium for Religious Sector Involvement in the White House Conf. on Aging	90-AT-0006	60,000
State Agencies on Aging (57 Awards)	White House Conf. on Aging		600,000
Johns Hopkins University	Maintaining State Activities for the White House Conference on Aging	90-AR-0030	9,000

POLICY RESEARCH AND DEMONSTRATIONS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Fall River Housing Authority	A Study of the Specialized Housing Needs of Diverse Groups	90-A-1651	$ 70,000
Portland State University	Transition from Work to Retirement Innovative Business Practices	90-AR-0021	75,000
Regents of the University of Michigan	Supporting Facilities for Research and Policy Development and Evaluation of the Field of Aging	90-A-1279	267,000
Hunter College	The Older Job Seeker: Barriers and Supports in Job Search	90-AR-0020	133,000
University of Iowa	Analysis of Factors Influencing the Housing Choices of Older People	90-AR-2118	3,000
Hunter College (CUNY)	Seasonal Vulnerability of the Old and Cold	90-AR-0010	66,000
Urban Institute	Impact of Inflation on Income and Expenditures of Older Americans	90-AR-2125	80,000
Urban Institute	Impact of Suburbanization on the Needs of Older Americans	90-A-1366	132,000
University of California	Fiscal Crisis and Tax Revolt: Impact on Aging Services	90-AR-0016	195,000
Wisconsin State Department of Health and Social Services	Home Equity Conversion Project	90-AR-0001	139,000
Hebrew Rehabilitation Center for Aged	Nationwide Study of Domiciliary Care	90-A-1659	185,000
Massachusetts Institute of Technology	Determinants of Housing Choice Among Elderly: Policy Implications	90-AR-2116	10,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
American Association of Community and Junior College	Community College Demonstration Project to Increase Small Business Ownership and Employment Opportunities for Older Persons	90-AD-0003	249,985
Gerontological Society	National Research Conference on Technology and the Aged	90-AR-0025	141,000

POLICY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California	National Aging Policy Study Center on Employment and Retirement	90-AP-0002	$ 159,955
National Council on Aging	NAPSC on Education, Leisure and Continuing Opportunities for Older Persons	90-AP-0001	159,976
University of Maryland	NAPSC for the Study of Women and Aging	90-AP-0006	159,597
Brandeis University	NAPSC on Income Maintenance	90-AP-0005	159,991
University of California	NAPSC on Health	90-AP-0003	159,892
Universtiy of Michigan	NAPSC on Housing and Living Arrangements for Older Americans	90-AP-0004	160,000

Appendix VIII

INDIVIDUAL RIGHTS AND RESPONSIBILITIES GRANTS TO STATE AGENCIES ON AGING TO PROVIDE SPECIALIZED STAFF TO DEVELOP AND SUPPORT ADVOCACY AND LEGAL SERVICES IN EACH AAA IN THE STATE

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Alabama	Advocacy Assistance Grant		$ 50,000
Arizona	" "		50,000
Colorado	" "		41,500
Connecticut	" "		45,042
Delaware	" "		50,000
District of Columbia	" "		50,000
Florida	" "		76,000
Idaho	" "		100,000
Illinois	" "		73,000
Indiana	" "		50,000
Kansas	" "		50,000
Louisiana	" "		50,000
Maine	" "		46,000
Maryland	" "		50,000
Massachusetts	" "		50,000
Minnesota	" "		50,000
Missouri	" "		50,000
Nebraska	" "		50,000
Nevada	" "		50,000
New Hampshire	" "		47,700
New Jersey	" "		50,926
North Dakota	" "		32,000
Ohio	" "		68,335

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Oklahoma	Advocacy Assistance Grant		50,000
Oregon	" "		100,000
Rhode Island	" "		49,000
South Carolina	" "		50,000
South Dakota	" "		18,000
Tennessee	" "		47,000
Texas	" "		33,000
Utah	" "		42,000
Vermont	" "		50,000
Washington	" "		100,000
Wisconsin	" "		50,000
American Samoa	" "		22,000
Puerto Rico	" "		50,000

BI-REGIONAL ADVOCACY ASSISTANCE CENTERS TO PROVIDE SPECIALIZED TRAINING AND ASSISTANCE TO STATE AND AAA LEGAL SERVICES PROGRAMS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Michigan Institute of Gerontology Ann Arbor, Michigan	Bi-Regional Advocacy Assistance Resource and Support Center Regions V and VII	HEW-105-79 3003	415,806
National Paralegal Institute Washington, D.C.	Bi-Regional Advocacy Assistance Resource and Support Center Regions III and IV	HEW-105-79 3002	627,182
National Paralegal Institute of California San Francisco, California	Bi-Regional Advocacy Assistance Resource and Support Center Regions IX and X	HEW-105-79 3005	428,706
Boston University Boston, Massachusetts	Bi-Regional Advocacy Assistance Resource and Support Center Regions I and II	HHS-165-80 C-013	495,000
Center for Public Interest Alston, Texas	Bi-Regional Advocacy Assistance Resource and Support Center, Regions VI and VIII	HHS-105-80 -C-043	460,630

NATIONAL LEVEL GRANTS TO DEVELOP TRAINING MATERIALS AND RESEARCH AREAS OF LAW OF PARTICULAR CONCERN TO THE ELDERLY

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Legal Services Corporation	National Support System for Advocacy Assistance Initiative	90-AD-0002	$ 379,150
National Citizens Coalition for Nursing Home Reform	Community Involvement in Improving the Nursing Home System	90-A-1821	240,970
American Bar Association	Bar Activation Project for the Elderly	90-AD-0001	80,638
Colorado Congress of Senior Organizations	Cooperative Senior Advocacy Project	8-AD-0007	6,666

Appendix IX

SERVING THOSE IN NEED - JOINING PUBLIC AND PRIVATE SECTORS

IMPROVING SYSTEMS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
County of L.A. - Area Agency on Aging	Community Analysis Techniques	90-A-1328	80,000
University of California	Self-Help and Advocacy for the Underserved Elderly	90-AR-0013	99,000
Scientific Analysis Corporation	Services to the Elderly Under Title XX: An Analysis of National Trends 1975-1979	90-A-1677	62,000
University of California, San Francisco	Study of the Interactions between Health Planning Agencies & AAA's	90-AR-0028	190,000
University of Kentucky	AAA's and the Provision of Mental Health Services for the Elderly	90-AR-0026	143,000
Portland State University	Effective Community Intervention for the Elderly	90-AR-0019	160,000
University of California, San Francisco	Funding Practices, Policies, and Performance of SUAs and AAAs	90-A-979	142,000
State of Texas, Governor's Committee on Aging	Texas Management Information System Project	90-AM-0008	52,650
New York State Office for Aging	An Integrated Statewide Infor-System for Aging Services in N.Y.	90-AM-0010	85,015
State of Connecticut, Dept of Aging	Model Statewide Service Data Reporting System	90-AM-0007	125,675
Ohio Commission on Aging	Ohio Aging Services Information System	90-AM-0009	85,240
Jefferson County, Alabama, Office of Senior Citizens Activities	Service Data Reporting System	90-AM-0011	97,494
Urban Health Institute, East Orange, N.J.	Experimental AAA/HSA Integration Project	90-A-1183	87,108
University of Illinois	Data Base Development for State Agencies on Aging	90-A-1603	90,000
The Assistance Group, Silver Spring, Maryland	Comprehensive Care System for Older People	90-A-1618	302,208
National Association of State Units on Aging	Aging Units Information System Project - Codifying and Disseminating Information	90-A-1657	70,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of D.C.	Yoga Relaxation - Meditation as Preventive Health Care	90-AR-2056	16,000
University of Michigan	Changing Properties of Retirement Communities	90-AR-0011	137,000
Mid Peninsula Health Services, Palo Alto, CA	Comprehensive Community Day Care Program for Frail Elderly	90-A-1836	120,621
Waxter Center, Baltimore, Maryland	Senior Center Care System	90-A-1820	165,068
Northern Kentucky Mental Health Retardation Regional Board, Covington, KY	The PLAC Senior Center	90-A-1607	79,794
Foundation for Comprehen- Health Services, Sacramento California	Model Medical and Health Care System for the Older Citizen of Sacramento	90-A-1610	128,000
Jamaica Service: Program for Older Adults, Inc. Jamaica, New York	Local CCS and Management Demonstration Project	90-A-1615	227,235
National Council on the Aging, Washington, D.C.	The Senior Center and the Community Care System	90-A-1736	89,336
University of Washington, Seattle, Washington	Service Demonstration Social Services to Low Income Elderly	90-A-1822	141,263
National Council on the Aging, Washington, D.C.	National Voluntary Organizations for Independent Living for the Aged	90-A-1184	162,250
Benjamin Rose Institute	Effects on Families of Caring for Impaired Elderly in Residence	90-AR-2112	46,000
Brandeis University	Decision Making for Home Care	90-A-1679	140,472
Philadelphia Corporation on the Aging, Philadelphia, Pa.	Service Management and In-Home Services for Frail Elderly	90-A-1081	178,596
Soma Clinic, Cambridge Massachusetts	Resocialization of Older Persons in the Older Role	90-A-1641	204,846
Community Social Services of Miami Valley	Adult Foster Living Project, Xenia, Ohio	90-A-1829	131,769
New York City Housing Authority, New York	Senior Resident Advisor Program	90-A-1639	139,347

IMPROVING COMMUNITY SERVICES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California	Alternative Designs for Comprehensive Service Delivery to the Elderly	90-A-1280	138,000
University of Michigan	Simulated Site Visits: Preparation for Relocation	90-AR-2039	600
Institute of Public Administration	Improving Transportation for Elderly: Study of Problems and Potential	90-AR-2114	10,000
Center for Studying Social Welfare and Community Development	Subsidized Taxi Programs	90-AR-0007	24,000
Human Services Coordination Alliance	Building Client Capacity to Access and Utilize Services	18-P-00158	272,000
University of Pennsylvania	Data Base on Emerging Services and the Elderly	90-A-1658	118,000
Miami Jewish Home and Hospital, Miami, Florida	Service Worker for Aged in Trouble	90-A-1835	179,534
The Caring Community, New York, Inc.	A Model in Community Integration	90-A-1815	98,516
Georgetown University	Maintaining the Elderly in the Community	90-A-1381	162,000
American Dietetic Association	Food Technologies and Service System and Technical Assistance for Nutrition Program	90-AR-0018	108,000
National Center on Black Aged	Community Revitalization as Perceived by Resident Older Persons	90-AR-0009	34,000
University of California	Effects of Retirement on the Utilization of Health Services	90-A-1669	14,000
Temple University	Assessment of Recent AoA Demonstrations: Social and Community Services	90-AR-0023	112,000
Temple University	Analysis and Dissemination of Community Care Systems Demonstration Results	90-AR-0004	146,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Washington, Seattle, Washington	Community-Based Comprehensive Care for the Elderly	90-A-1817	193,902
Columbia University	Cross National Study of Cost Benefits of Alternative Service Treatment Modalities	90-A-1649	205,000
Philadelphia Geriatric Center	Changing Service Needs of Older Tenants	90-AR-0006	138,000
University of Chicago	Nursing Home Information Dissemination Project	90-AR-0029	40,000
American Association of Homes for the Aging	Resident Participation in Governance of Homes for the Aging	90-A-0017	160,000
Community Research Applications	Cost Effect and Benefits Associated with Domiciliary and Intermediate Care	90-A-1672	153,000
Columbia University	Characteristics of Institutions Successful in Promoting Innovative Programs for the Aged	90-AR-0005	115,000
Southwest Mississippi AAA	Claiborne County Demonstration Rural Elderly Housing Project	90-AM-2126	20,500
Area Agency on Aging of Western Michigan	Lake County Congregate Housing Demonstration Project	90-AM-2129	60,000
South Dakota Department of Social Services	To Provide service to residents of Congregate Housing Project in Charles Mix County	90-AM-2134	55,000
Eastern Oregon County Development Council	Support Services to FmHA/AoA Sponsored Demonstrations Congregate Housing for Rural Elderly	90-AM-2135	50,171
Eastern Shore Community Development Group (Virginia)	Support Service for Congregate Housing for Elderly in Accomack	90-AM-2128	40,793

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Rio Grande Council of Governments, Area Agency on Aging (New Mexico)	Elderly Congregate Housing Project	90-AM-2130	30,359
Southern Iowa Council of Governments, Area XIV Agency on Aging	Congregate Housing Demonstration Program	90-AM-2131	85,000
New Hampshire State Council on Aging	Carrol County Rural Congregate Housing Demonstration	90-AM-2132	26,985
County of Riverside Office on Aging (California)	A Program of Supportive Services for a Rural Congregate Housing	90-AM-2133	-0-
Chautauqua County Office for the Aging (New York)	Congregate Housing for the Elderly (Supportive Services)	90-AM-2127	-0-

STRENGTHENING FAMILY SUPPORT

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California	A Youth Support System for the Frail Elderly	90-AR-2191	$ 71,000
National Bureau of Economic Research	Measurement of Intrafamily Transfers and their Effects on Individual Behavior	90-AR-2119	8,000
Fordham University	The Impact of the Entry of the Formal Organization on Existing Informal Networks of Older Americans	90-A-1329	145,000
Hebrew Rehabilitation Center for the Aged	A Study of Informal Support Network of the Needy Elderly	90-A-1294	118,000
Dartmouth College	Demonstration of Self-Help Approach to the Coordination of Human and Health Services	90-AR-1949	141,000
University of Michigan, Ann Arbor, MI	Development and Evaluation of Community-Based Support Groups for Families of Aged Persons	90-A-1608	79,000
Community Service Society of New York, New York, N.Y.	Natural Supports Program Community Development Groups	90-A-1609	150,802
University of Michigan, Ann Arbor, MI	Peer Support System	90-A-1617	33,733
Department of Elderly Affairs, Providence, R.I.	Family and Community Support System Project	90-A-1813	95,835
University of Maryland Baltimore, Maryland	A Controlled Trial of Caregiver Training for the Elderly Impaired in Urban and Rural Settings	90-A-1824	133,428
New York University School of Medicine, N. Y., N. Y.	Providing a Missing Link in the Chain of Support Systems	90-A-1825	146,428

STRENGTHENING FAMILY SUPPORT (CONT.)

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Southern California, Wash., D.C.	Requisites for Neighborhood Capacity Building	90-A-1830	$ 88,325
Franklyn/Hampshire CMHC	Natural Support System of the Non-Institutionalized Rural Elderly	90-A-1834	89,550

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Cherokee Nation of Okla.	Title VI	AI-6	$ 65,000
Mescalero Apache Tribe	"	AI-27	65,000
Citizen Band Potawatomi	"	AI-25	70,000
Pueblo of Laguna	"	AI-29	70,000
Osage Tribe of Oklahoma	"	AI-31	100,000
Jicarilla Apache Tribe	"	AI-34	65,000
Seminole Nation of Okla.	"	AI-35	75,000
Pueblo of Zuni	"	AI-38	87,500
Seneca-Cayuga Tribe of Oklahoma	"	AI-41	70,000
Pueblo of Isleta	"	AI-42	65,000
San Juan Pueblo Tribe	"	AI-45	70,000
Santa Clara Pueblo	"	AI-47	65,000
The Chickasaw Nation	"	AI-53	65,000
Eight Northern Indian Pueblos Council	"	AI-54	65,000
Creek Nation of Oklahoma	"	AI-58	100,000
Miami Tribe of Oklahoma	"	AI-63	80,000
Six Sandoval Indian Pueblos, Inc.	"	AI-67	87,500
Quapaw Tribe of Oklahoma	"	AI-71	75,000
Otoe-Missouria Tribe	"	AI-75	70,000
Pawnee Tribe of Oklahoma	"	AI-77	80,000
Kickapoo Tribe of Okla	"	AI-78	100,000
Pueblo of Taos	"	AI-82	75,000
Santo Domingo Tribe	"	AI-87	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
The Kiowa Tribe of Oklahoma	Title VI	AI-88	$ 70,000
Omaha Tribe	"	AI-16	70,000
Prairie Band of Potawatomi	"	AI-20	65,000
Santee Sioux Tribes	"	AI-7	65,000
Kickapoo Tribe of Kansas	"	AI-60	65,000
United Tribe of Kansas and Southeast Nebraska Inc.	"	AI-76	65,000
Confederated Salish & Kootenai Tribes	"	AI-13	70,000
Standing Rock Sioux Tribe	"	AI-22	65,000
Yankton Sioux Tribe	"	AI-26	65,000
Northern Cheyenne Tribe	"	AI-39	65,000
Southern Ute Community	"	AI-57	65,000
Assiniboine and Sioux Tribes	"	AI-85	65,000
Blackfeet Tribe	"	AI-55	70,000
Uintah and Ouray	"	AI-58	70,000
Chippewa-Cree Tribe	"	AI-63	70,000
Ute Mountain Ute Tribe	"	AI-66	70,000
Cheyenne River Sioux Tribe	"	AI-70	65,000
Oglala Sioux Tribal	"	AI-83	70,000
Hopi Health Association	"	AI-12	70,000
White Mountain Apache Tribe	"	AI-17	70,000
Salt River Indian Community	"	AI-4	65,000
Papago Tribe	"	AI-28	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
The Navajo Tribe	Title VI	AI-3	$ 70,000
Pascua Yaqui Tribe	"	AI-30	70,000
Inter-Tribal Council of Nevada, Inc.	"	AI-32	65,000
San Carlos Apache Tribe	"	AI-46	65,000
Hopi Tribal Council	"	AI-73	75,000
Washoe Tribe of Nevada & California	"	AI-79	65,000
Shoshone-Bannock Tribe	"	AI-11	70,000
South Puget Intertribal	"	AI-21	70,000
North West Washington	"	AI-5	70,000
Ketchikan Indian Corp.	"	AI-2	65,000
Yakima Indian Nation Area Agency on Aging	"	AI-40	65,000
Lower Elwha Tribal Council Tribal Elders Program	"	AI-43	65,000
Quinault Indian Nation	"	AI-44	65,000
Puyallup Tribal Health Authority	"	AI-56	75,000
Kodiak Area Native Assoc.	"	AI-9	70,000
Confederated Tribes of the Umatilla Indian Res.	"	AI-33	75,000
Muckleshoot Indian Tribe	"	AI-49	65,000
Lummi Indian Business Council	"	AI-64	70,000
Colville Confederated Tribes	"	AI-65	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Passamaquoddy Tribe	Title VI	AI-01	$ 65,000
Tonawanda Band of Senecas	"	AI-61	65,000
Mississippi Band of Choctaw Indians	"	AI-48	75,000
Eastern Band of Cherokee Indians	"	AI-52	70,000
Keweenaw Bay Indians	"	AI-14	65,000
Inter-Tribal Council of Michigan	"	AI-19	70,000
Stockbridge-Munsee	"	AI-15	70,000
Red Cliff Band of Lake Superior	"	AI-18	65,000
Wisconsin Winnebago Business Community	"	AI-24	70,000
Mille Lacs Reservation Business Community	"	AI-10	70,000
Bad River Tribe	"	AI-36	65,000
Red Lake Band of Chippewa Indians	"	AI-37	75,000
Menominee Indian Tribe of Wisconsin	"	AI-51	65,000
St. Croix Tribal Council	"	AI-09	65,000
Sault Ste. Marie Tribe of Chippewa	"	AI-68	70,000
Fond du Lac Reservation Business Committee	"	AI-69	70,000
Lac Courte Oreilles Tribal Governing Board	"	AI-60	70,000
Choctaw-Nation Of Oklahoma	"	AI-23	100,000
Pueblo of Acoma Tribal	"	AI-6	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Eastern Washington Indian Consortium	Title VI	AI-84	$ 70,000
Nez Perce Tribe of Idaho	"	AI-86	70,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
California State University	The Minority Elderly: "Equal Opportunity" Myth or Reality	90-A-1665	$ 14,000
International Institute of L. A.	Spanish Language Research Project for Older Persons	90-AR-0003	138,000
Asociacion Nacional Pro Personas Mayores	Hispanic Support Systems and the Chronically Ill Older Hispanic	90-AR-0014	192,000
University of Michigan	Factors Impacting on the Well-Being of Elderly Black Women	90-AR-2183	800
National Center on Black Aged	Informal Social Networks in Support of Elderly Blacks in the Black Belt	90-A-1290	23,000
San Diego State University Foundation	Codification of Research on Minority Elderly	90-AR-0022	184,000
National Indian Council on Aging	National Advocacy to Assist Access of Older American Indians to Services and Entitlements of the Older Americans Act and Other Public Programs	90-AM-2192	336,398
National Center on Black Aged	National Aging Organization Projects Program	90-AM-2197	349,857
Asociacion Nacional Pro Personas Mayores	Project "Mano A Mano"	90-AM-2198	349,052
Special Service for Groups	Pacific/Asian Elderly Coalition	90-AM-2199	284,692
The Mexican-American Community Agency	The Hispanic Service Advocate Program (HSAP)	HAS-210	107,000
New Mexico State Agency on Aging	Economic and Resource Development Activities for Elderly New Mexicans	HAS-202	60,000
Amigos Del Valle	Amigos Del Valle Information and Referral Model Project to Increase Hispanic Access to Service	HAS-212	85,000

REACHING OUT TO MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Little Havana Activity Center	Hispanic Opportunities Program	HAS-201	$ 60,000
Amigos De Valle - Phar, Texas	Resocialization and Rehabilitation of High Risk Elderly	90-A-1091	133,103
New York City Department for Aging, NYC, NY	Minority Service Enhancement Proj.	90-AM-204	80,000
Area Agency on Aging, Region I, Phoenix, AZ	Centro de Los Ancianos	09-AM-030	80,000
Area Agency County of San Diego, California	Prototype for Area Agency on Aging	09-AM-029(01)	130,000
Inter Tribal Council of Arizona, Phoenix, AZ	Alternative Models for Operation Comprehensive, Coordinated Services to Elderly on Indian Reservations	09-AM-028	54,617
University of Louisville Foundation, Louisville, KY	Community Education Model for Network Building Among Minority Elderly	90-A-1826	89,814

SPECIAL POPULATIONS AND SPECIAL PROBLEMS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
American Foundation for the Blind	Uses of Self-Help and Mutual Aid in Compensating for Sensory Changes in Old Age	90-AR-0012	$ 101,000
Metropolitan Commission on Aging of Syracuse and Onandago County, New York	Demonstration Project on Elderly Abuse	AT-2A57-A	66,000
Rhode Island Department of Elder Affairs	Elder Abuse Program	01AM-00017	55,000
Mon Valley Health and Welfare Council, Inc. Monessen, Pa.	Community Support Systems for Rural Frail Elderly	03-AD-204	83,447
Area Agency on Aging V. Lacrosse, Wisconsin	Rural Western Wisconsin Service Delivery System	WI-0-244	51,712
Illinois Department on Aging Springfield, Ill.	Rural Day Care for Elders	IL-0-0264	73,355
Gateway Area Developmen District Owingsville, KY	Gateway Focus on Elderly Health & Social Services Rural Elderly	04-AMD-0305	47,523
New York State Office for Aging, Albany, NY	Rural Aging Services Project	90-AMD-012	83,488
Luthern Welfare Service of NE Pennsylvania	Hospice Demonstration Project	90-A-1828	160,000
Seattle King County Div on Aging, Seattle, Washington	Pacific/Asian Elderly Service Development Project	10AG-0009(01)	118,213
Denver Regional Council of Governments	Model to provide access to medica care and social services for Immigrant Elderly	8-AM-8 (01)	60,000
North Central Regional Planning Commission, Ridgeway, Pennsylvani	Health Education and Social Services	90-A-1511	100,000
Santa Monica Hospital Medical Center for th Partially Sighted, Santa Monica, CA.	Comprehensive Community Care System Partially Sighted Older Persons	90-A-1600	97,213

SPECIAL POPULATIONS AND SPECIAL PROBLEMS (CONT.)

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Hospice of the Valley, Phoenix Arizona	Hospice Project Core	90-A-1612	$ 100,000
Hospice of Santa Barbara, CAL	Hospice Outreach Program Elderly Terminally Ill	90-A-1827	126,121
University of Michigan, Lansing, Michigan	Capacity Building on Mental Health and Substance Abuse	90-A-1818	93,678
Continental Asso. Funeral & Memor. Societies, Inc. Washington, D. C.	Model Consumer Education Project and Funeral & Burial Costs	90-A-1816	77,000
Ohio State School for the Deaf Alumni (Columbus Colony) Westerville, Ohio	Providing for the Elderly Deaf in Total Community Planning	90-A-1640	167,000
U.S. Conference of Mayors	Project TEAM - (Techniques for Effective Administration and Management in Aging)	90-AM-5	181,733
National Association of Counties Research Inc.	County Resource Development for Older Americans	90-AM-3	119,779
United Neighborhood Centers of America	Improving Programs and Services to the Elderly	90-AM-6	74,984
Western Gerontological Society	Mobilizing Resources for Underserved Elders	90-AM-2	175,231
Urban Elderly Coalition	Urban Elderly National Aging Program	90-AM-4	162,920
National Association of State Units on Aging	State and Area Agency Planning and Program Development	90-AM-1	378,995
Commonwealth of Massachusetts Department of Elder Affairs	Massachusetts Elder Abuse Project	01AM-000018	125,000

Appendix X

LONG TERM CARE - MOVING TOWARD A CONTINUUM OF CARE FOR THE FUNCTIONALLY DISABLED

LONG TERM CARE GERONTOLOGY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Southeastern New England LTCGC, Brown University Providence, R.I.	Long Term Care Gerontology Center	90-AT-2164	$425,000
UCLA/USC LTCGC Los Angeles, Calif.	"	90-AT-2167	$424,839
Columbia University Center for Geriatrics & Gerontology New York, N.Y.	"	90-AT-2155	$425,000
Suncoast Gerontology Center for Health and LTC, Univ. of South Florida, Tampa, Florida	"	90-AT-2157	$424,996
Univ. of Washington LTCGC Seattle, Washington	"	90-AT-2152	$424,692

LTC GERONTOLOGY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Arizona Tucson, AZ.	Long Term Care Gerontology Center	90-AT-2166	$109,652
Benjamin Rose Institute Cleveland, Ohio	"	90-AT-2153	$103,032
University of Kansas College of Health Sciences & Hospital, Kansas City, KAN.	"	90-AT-2154	$105,842
State University of New York - LTC Consortium Syracuse, N.Y.	"	90-AT-2158	$109,652
Univ. of Arkansas for Medical Sciences, Little Rock, Ark.	"	90-AL-0005	$145,127
Duke Univ. Medical Center Durham, N.C.	"	90-AL-0001	$155,000
Meharry Medical College Nashville, TN.	"	90-AL-0007	$154,858
Univ. of Oregon Health Sciences Center, Portland, Oreg.	"	90-AL-0002	$154,999
Univ. of Pittsburgh Pittsburgh, Pa.	"	90-AL-0004	$153,031

LTC GERONTOLOGY CENTERS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Univ. of Tennessee for Health Sciences Memphis, TN.	Long Term Care Gerontology Center	90-AL-0003	$150,968
Virginia Center on Aging Virginia Commonwealth Univ., Richmond, Va.	"	90-AL-0006	$153,762
Association of American Medical Colleges	Coordination and Support for LTC Centers	90-AL-0009	$339,822
KLM	Technical Assistance To LTC Centers		$ 63,000

GERIATRIC FELLOWSHIPS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of California at Los Angeles	Geriatric Fellowship Program	90-AT-2050	$100,000
Mt. Zion Hospital & Medical Center San Francisco, Ca.	"	90-AT-2049	$100,000
Harvard Univ. Medical School	"	90-AT-2051	$100,000
Boston Univ. School of Medicine	"	90-AT-2054	$100,000
Duke Univ. Medical Center	"	90-AT-2053	$100,000
University of Washington	"	90-AT-2052	$ 85,361

CHANNELING DEMONSTRATIONS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
1) State of Florida	Channeling Demonstration Project		932,896
2) State of Hawaii	"		850,000
3) State of Kentucky	"		1,009,085
4) State of Maine	"		780,270
5) State of Maryland	"		976,778
6) State of Massachusetts	"		691,499
7) State of Missouri	"		765,061
8) State of New Jersey	"		985,534
9) State of New York	"		729,693
10) State of Ohio	"		903,883
11) State of Pennsylvania	"		1,023,310
12) State of Texas	"		759,015
	Jointly funded with HCFA AoA Total		5,385,243
Mathematica Policy Research	Evaluation of the National LTC Channeling Demonstrations		2,414,260
Temple University	Technical Assistance to National LTC Channeling Demonstration Projects		750,000

STATE SYSTEM DEVELOPMENT

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
California/Hlth. & Welfare Agency	State System Development Grant	90-AS-0010	$115,000
Delaware/Dept. of Hlth. & Social Services	"	90-AS-0011	83,467
Illinois/Dept. of Public Aid	"	90-AS-0008	104,549
Idaho/Office of Aging	"	90-AS-0004	91,360
Colorado/Dept. of Social Services	"	90-AS-0005	100,282
Washington/Dept. of Hlth. & Social Services	"	90-AS-0014	110,905
Oregon/Dept. of Human Resources	"	90-AS-0007	100,126
Minnesota/Dept. of Hlth.	"	90-AS-0013	115,000
Rhode Island/Dept. of Social & Rehabilitation Services	"	90-AS-0001	99,505
Wisconsin/Dept. of Hlth. & Social Services	"	90-AS-0006	98,457
Arkansas/Office on Aging	"	90-AS-0009	81,170
District of Columbia/Dept. of Human Services	"	90-AS-0015	85,000
S. Dakota/Dept. of Hlth.	"	90-AS-0003	100,924
N. Carolina/Dept. of Human Resources	"	90-AS-0002	110,000
New Hampshire/Division of Welfare	"	90-AS-0012	84,168
Arkansas Office on Aging Little Rock, Ark.	Service Management/Screening Project	90-A-1737	200,680
Pennsylvania Office for the Aging Harrisburg, PA.	Long Term Care Planning and Development	90-A-1398	90,000

STATE AND COMMUNITY MODEL BUILDING

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Grace Hill Neighborhood Health Center St. Louis, Missouri	AoA/HSA Demonstration Project	90-AR-2090	$ 99,944
East Harlem Council for Human Services New York, N.Y.	"	90-AR-2092	-0-
Providence Ambulatory Health Care Foundation Providence, R.I.	"	90-AR-2089	$100,000
District of Columbia General Hospital	"	90-AR-2091	-0-
Centro de Salud de la Communidad de San Ysidro	"	90-AR-2088	$ 94,500
Yakima Indian Nation Area Agency on Aging Toppenish, Washington	"	90-AR-2094	$ 84,306
Cherokee Nation Health Department Tahlequah, Oklahoma	"	90-AR-2095	$ 53,924
Navajo Tribe Fort Defiance, Arizona	"	90-AR-2093	-0-
U.S. PHS Hospital Baltimore, Maryland	"		$100,000
U.S. PHS Hospital Brighton, Mass.	"		$100,000
U.S. PHS Hospital Seattle, Washington	"		$ 95,406
On Lok Senior Health Services	On Lok Community Care Organization for Dependent Adults	18-P-00156	$248,000

STATE AND COMMUNITY MODEL BUILDING

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Monroe County, Inc Program, Inc. Rochester, N.Y.	Extending Access	90-A-1602	$176,400
Oregon Department of Human Resources Salem, Oregon	Oregon Senior Resources Continuum Demonstration	90-A-1606	$148,781
Senior Citizens Services Inc. Memphis, Tn.	Deinstitutionalization Program	90-A-1619	$177,069
Edgerton Medical Research Foundation Wichita, Kansas	Adult Restorative Services	90-A-1620	$107,717
Mental Health Program Inc. Boston, Mass.	Geriatric Assessment and Resource Center Model Project	90-A-1621	$174,300
Pima County Board of Supervisors Tucson, AZ.	Community Services Program	90-A-1643	$244,748
Multidisciplinary Gerontology Center of Iowa, Ames, Iowa	The Assessment and Evaluation of the Functionally Dependent Elderly: A Community Project	90-A-1645	$150,000
Family Hospital Milwaukee, Wis.	Wisconsin Regional Geriatric Center	90-A-2186	$ 88,000
NYC Dept. for the Aging New York, N.Y.	The Delivery of Medical Social Services to the Home Bound Elderly: A Demonstration of Intersystem Coordination	90-AM-2187	$329,000

POLICY FORMULATION AND INFORMATION EXCHANGE 338,000

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Conference on Social Welfare	Knowledge Dissemination on Long Term Care	90-AL-0008	$338,283

Appendix XI

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Florida	Focusing on Training for Careers in Services to the Frail & Vulnerable Elderly	04AG000017	101,111
University of So. Florida	Career Training for Community Services Administrators in Gerontology	04AG000009	92,360
Georgia State University	Community Geron Specialists Training	04AG000008	138,036
Duke Medical Center	Multidisciplinary Prep for Careers in Geriatric Care	04AG000006	120,717
Memphis State University	University-wide Degree Program in Human Services Aging	04AG000019	48,958
University of Michigan	Gerontology Career Preparation Program	AA00P MI902	145,741
Wayne State University	same as above	AAGCPM19	150,889
Maimi University	Multiple Career Tracks for Working with Older American		120,469
Ohio University	Gerontology Career Prep Pgm	AACCPOM902	106,460
No. Texas State University	Same as above	6AG133	117,200
University of Texas at Arlington	Training of Personnel in Service Delivery to the Mexican-American Elderly	6AG138	123,841
University of Rhode Island	Specialized Career Training in Aging	01AT000005	95,844
Rutgers University	Same as Above	AT2A36B	135,487
Hunter College	Geron Career Preparation	H2A41B	137,131

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Syracuse University	Geron Career Preparation	AT2A42-B	141,498
University of Maryland Center on Aging	Same as Above	03AT106	125,390
Pennsylvania State University	Multidisciplinary Training for Specialized Careers in Aging Services	03AT101	117,786
Temple University	Gerontology Career Prep.	09AT110	109,082
University of Pennsylvania	Same as Above	03AT104	113,957
Virginia Commonwealth	Same as Above	08AT106	116,074
University of District of Columbia	Multidisciplinary Undergraduate & Graduate Career Training	08AT112	115,045
West Virginia University	Multidisciplinary Geron Career Training in the Rural Setting	03AT111	90,435
University of Alabama	Geron. Career Prep	04AG000015	112,632
Wichita State University	Same as Above	90AT2194	82,550
University of Utah	Integrated Geriatric/Geron Curriculum in the Health Sciences	8AT2	93,107
Dan Diego State University	Career Prep with an Emphasis on Serving the Minority Elderly	09AT015	124,197
University of Calif.	Training Program in Multidisciplinary Applied Geron.	09AG014	104,673
Oregon State University	Geron Career Preparation	10AT0003	132,893

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
University of Oregon	Geron Career Preparation	10AT0002	117,731
University of Washington	" " "	10AT0001	137,276
University of So. California	" " "	09AT021	
University of Massachusetts	Development for Careers in Gerontology	01AT000004	152,051
National Center for Black Aged	Capacity Building for Minority Institutions in Geriatrics & Gerontology	08AT100	174,488
Norfolk State University	Geron Career Preparation	08AT113	95,325
University of Alabama in Birmingham	" " "	04AG00005	162,872
University of Kansas/Kansas State U	Kansas Consortium	07AT0179	156,411
University of Missouri/Joint Centers on Aging Studies	Gerontology Career Prep.	07AT0180	95,585
Northeastern California Higher Education Council	Model Gerontological Training for Rural Areas	09AT017	113,418
University of Hawaii	Geron Career Preparation	09AT019	170,000
University of Connecticut	Training Program to Train Social Work Students for Career in Aging	01AT000003	77,537
Brandeis University	Training for Policy and Management Careers in Aging	01AT000001	114,151

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
New York University	Medical Training in Geriatrics and Geron - A Decol Approach	H2A38B	98,878
University of MD. School of Medicine	Physical Therapy Training to Care for the Vulnerable Elderly: An Operational Model	03AT102	84,935
University of MD. School of Social Work and Community Planning	Specialization in Aging Administration	03AT108	101,692
George Washington University	Service Providers Legal Training	08AT109	101,089
University of Miami	Training Program in Gerontological Clinical Psychology	04AG000011	69,116
Fisk University	Graduate Master of Arts Pgm in Gerontology	04AG000012	114,768
Northwestern University	Geron Career Prep	A00TI19	52,096
University of New Mexico	Train Elderly Minorities as Paralegals and Minority Law Students to Serve Elderly, Minority Rural People	6AG137	114,786
University of Texas	Undergraduate Ed for Persons Projected to Work in AoA Supported/Stimulated Areas of Aging	6AG134	63,608
University of Nebraska	Special Career Prep Pgm in Geron for Allied Health Professionals	07AT0181	99,929
University of Arizona	Long Term Care Admin Pgm	09AT018	89,236
University of Calif.	Geron Career Prep	09AT016	113,418
University of Bridgeport	Career Enhancement in Mental Health Work with the Aged	01AT000002	31,769
Springfield Technical Community Coll	Geron Career Prep	01AT000006	69,998

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
College of St. Elizabeth	Geron Career Prep	AT2A40B	59,749
Union College	Geron Aide Pgm	AT2A43B	51,544
Medgar Evers College	Cultural/Social Approach to Health Care Needs of the Aging Individual and Family in the Inner City	AT2A39B	92,084
Rockland Community College	Development of Career Training in Geron for Minority Group Students	AT2A45B	72,983
St. Thomas Aquinas College	Geron Career Prep	AT2A37B	70,060
North Country Community College	Multi-Faceted Pgm in Rural Geron	AT2A46B	79,116
Virginia Union University	Geron Career Prep	03AT107	77,541
Clark College	Geron Training Project	04AG000014	30,498
Murray State University	Career Training Aging for Social Planning and Helping Professions	04AG000004	75,537
Wayne Community College	Geriatric Technician Training Pgm	04AG000010	93,911
LeMoyne-Owen College	Geron Career Prep	04AG000016	66,656
Tennessee State University	Career Prep for Human Services Practitioners in Geron	04AG000018	55,630
Tusculum College	Geron Career Development Pgm	04AG000007	67,623
Madonna College	Activity Therapy in Geron Pgm	AA00PMI903	67,062

IMPROVING CAPACITY TO SERVE OLDER PEOPLE
CAREER PREPARATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
College of St. Scholastica	Flexible Multidisciplinary Training Pgm in Aging at Undergraduate Level		67,062
Minneapolis Community College	Geron Career Prep	AA00PMN901	83,827
University of Minnesota Technical College	Services for the Rural Elderly	AA00PMN902	44,669
Southern University	Aging Studies Career Training Grant	6AG130	111,580
Paul Quinn College	Geron Career Prep Pgm for BA Level Social Workers and Other Professionals Working with the Aged	6AG132	38,875
Prairie View A&M University	Multidisciplinary Undergraduate Career Training Pgm Specializing in Rural Geron	6AG136	77,517
St. Edwards University	Geron Career Prep	6AG135	62,697
Weber State College	Geron Career Prep	8AT1	64,168
University of Arkansas at Pine Bluff	Geron Career Prep	6AG131	68,438
Tougaloo College	Geron Career Prep		60,800
Southside Virginia Community College	Geron Career Prep		28,000
Various Institutions	24 Grants to Prepare Dissertations in Aging		154,000
Gerontological Society	Continuum of LTC: Health Care of the Elderly	90AR0002	110,000

ENHANCING CAREERS FOR MINORITIES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
San Diego State University Foundation	Minority Research Associates	90AT2	74,980
North Texas State University	MRAP in Hispanic Aging	90AT1	54,738
Scripps Foundation Gerontology Center Miami University	Social Science Schlors in Minority Gerontology: Training & Research	90AT0004	68,616
Syracuse University	MRAP	90AT0003	74,775
State University of New York at Buffalo	MRAP	90AT0005	23,816

DEVELOPMENT OF CONTINUING EDUCATION AND TRAINING MATERIALS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Ohio State University	Working with Older People	90 AT 0014	24,732
National Council on Aging	Senior Center & Community Focal Point Staff Capacity Building	90 AT 0011	171,831
University of Iowa	Capacitating Personnel for Implementing Community Long Term Care Systems: Training the Trainers Workshop	90 AT 0023	39,949
Miami Dade Community College	Improvement of Service Delivery to Low Income Minority & Economically Disadvantaged Older Persons	90 AT 0027	83,754
Research & Foundation of SUNY	Dissemination & Utilization of Basic Adult Services: A Model Curriculum	90 AT 0010	23,066
Eastern Washington University	Gerontological Uses of History: Development, Testing & Dissemination of Training Materials	90 AT 0015	24,206
East Central Oklahoma State University	Utilization of Curricula & Instructional Materials Concerning the Older Handicapped Individual	90 AT 0013	17,021
National Council on Aging	Continuing Education for Group Program Personnel Working with the at Risk Elderly	90 AT 2098	135,230

DEVELOPMENT OF CONTINUING EDUCATION AND TRAINING MATERIALS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Home Caring Council, Inc.	Supervisors in Home Services	90 AT 2099	157,079
University of Kentucky Research Foundation	Effective Patient Techniques for Use with the Aging Patient	90 AT 2097	17,307
Community Nutrition Institute	Technical assistance and training for aging organizations involved in management of nutrition service	HH 105 80 P 071	184,900
American Indian Professional Services	Training & technical assistance to Indian Tribal Organizations for development of comprehensive and coordinative service systems for older American Indians	HHS 105 80 P	238,792
International Center for Social Gerontology	Technical Assistance: Elderly Housing and Related Services	90 AT 1214	249,999
National Council of Senior Citizens	Educating Service Providers on How to Respond Effectively to Older Americans Adversely Affected by Crime	90 AT 0024	39,860
(To be awarded in FY 81)	Technical assistance for the aging network in the area of fiscal management	SA 80 3018	264,274

DEVELOPMENT OF CONTINUING EDUCATION AND TRAINING MATERIALS

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
National Association of State Units on Aging	Orientation of Aging Service Personnel to the Older Americans Act	90 AT 0012	98,000
National Association of State Units on Aging	NASUA Information System Development and Training	90 AT 0025	90,000
Washington School of Psychiatry	Delivering Services for Community Care of the Aged	90 AT 0017	108,972
National Association of Area Agencies on Aging	Continuing Education for Area Agencies on Aging: A Developmental Process	90 AT 0026	47,100
University of Washington	Health Promotion with the	90 AT 0016	85,774
Cemrel, Inc.	Training of Service Providers in Establishing Arts and Humanities Programs for Older Adults	90 AT 0020	79,034
American Personnel and Guidance Association	Gerontological Counseling: Continuing Education for Counselors and Related Personnel	90 AT 2100	169,864

MARSHALLING RESOURCES

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Center for Public Management		HEW 105 79	4,293
Center for Public Management	National Assistance to AoA in the Development of the Regional Education and Training Program	HEW 105 80 3025 HHS 105 80	213,781
Ten Reg. Contractors:			
Reg I, J. Snow Public Health	Coordination & Assistance for Education and Training	C-016	125,799
Reg. II, Kirschner Associates		C-021	136,837
Reg. III, Temple U		C-005	98,937
Reg. IV, Kirschner Associates		C-011	133,986
Reg. V, Kirschner Associates		C-012	149,977
Reg. VI, North Texas State		C-014	141,833
Reg. VII, University of Kansas		C-020	129,852
Reg VIII, Development Associates		C-018	113,742
Reg. IX, Western Gerontological Soc.		C-028	131,854
Reg. X, Kirschner Associates		C-004	148,967
Ten Regional Contractors	Amendment to Task for Long Term Care Workshops		143,218

IMPROVING SKILLS OF PERSONNEL

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Connecticut	State Education & Training	1A38	67,728
Maine	" " " "	1A45	30,000
Massachusetts	" " " "	1A40	130,000
New Hampshire	" " " "	1A41	30,000
Rhode Island	" " " "	1A42	30,000
Vermont	" " " "	1A43	30,000
Delaware	" " " "	3A70	30,000
District of Columbia	" " " "	3A71	30,000
Maryland	" " " "	3A72	73,313
Pennsylvania	" " " "	3A68	279,569
Virginia	" " " "	3A73	92,663
West Virginia	" " " "	3A74	42,448
Alabama	" " " "	4A2	76,966
Illinois	" " " "	AOA-IL-IVA-79	227,733
Indiana	" " " "	AoA-IN-IVA-79	105,504
Michigan	" " " "	AoA-MI-IVA-79	167,012
Minnesota	" " " "	AoA-MN-IVA-79	84,819
Ohio	" " " "	AoA-OH-IVA-79	213,284
Wisconsin	" " " "	AoA-WI-IVA-79	101,653
Louisiana	" " " "	6A32	70,383
Guam	" " " "	9A3	15,000
Office on Aging, Dept of Health & Social Service, State of Alaska	Title IV-A Training	10-A-406-79	10,000

DISSEMINATION AND UTILIZATION

RECIPIENT	PROJECT TITLE	PROJECT NUMBER	AMOUNT OF AWARD
Franklin Research Center	Collect Training Materials in Aging for Dissemination	HEW 105793010	31,303
Franklin Research Center	SCAN Resource Center on Social Behavioral/Social Practice	HHS 105 C 084 014	404,973
Sarage Information Service	To search and analyze selected un-line data bases to determine frequency and content of geron literature	SA 80 6601	4,950
University of Michigan	Dissemination & Utilization: Census Data as a Planning Tool	90 AR 0015	133,000
American Institute for Research	Gerontological Research Institute	90-AR-2173	49,000
University of Southern California	Psycho-Social Impacts of Alternative Transportation Choice of the Elderly	90 AR 0008	20,000

APPENDIX XII

1980 Title VI Regional Information Chart

Region	Total Title V grants awarded by Region	Total Indian population being served by Title VI by region	Total grant budget under Title VI by region	States within region that received title VI funding	Number of Indian tribes by region/State that received Title VI funding	Total Indian population being served by Title VI programs by States	Total Title VI funds awarded by States
I	1	80	$ 65,000	Maine	1	80	$ 65,000
II	1	93	65,000	New York	1	93	65,000
IV	2	402	145,000	Mississippi N. Carolina	1 1	272 130	75,000 70,000
V	13	1,608	890,000	Michigan Minnesota Wisconsin	3 3 7	332 522 754	205,000 215,000 470,000
VI	26	12,601	1,975,000	Oklahoma New Mexico	14 12	10,372 2,229	1,120,000 855,000
VII	5	464	330,000	Nebraska Kansas	2 3	213 251	135,000 195,000
VIII	12	1,237	810,000	Utah N. Dakota Colorado S. Dakota Montana	1 1 2 3 5	118 90 195 283 551	70,000 65,000 135,000 200,000 340,000
IX	10	1,233	685,000	California Nevada Arizona	1 2 7	135 155 943	70,000 130,000 485,000
X	15	2,087	1,035,000	Oregon Alaska Idaho Washington	1 2 2 10	262 250 346 1,229	75,000 135,000 140,000 685,000
	85	19,805	$6,000,000	23 States	85	19,805	$ 6,000,000

ADMINISTRATION FOR NATIVE AMERICANS

HUD/HHS SPECIALIZED INDIAN HOUSING PROJECT

In August 1978, the Intra-Departmental Council on Indian Affairs entered into a formal agreement with the Department of Housing and Urban Development for joint support of a project to provide specialized human care facilities and services on five Indian reservations. The five tribes selected to participate in the project were Navajo, Hopi, Zuni, White Mountain Apache and San Carlos Apache. The project was designed to maintain the traditional extended family concept by providing services and housing for tribal members of all ages—including components for service to the elderly as part of the overall specialized housing project.

HUD and HEW jointly funded a grant to build the capacity of the tribes to assess the housing and service needs of the elderly, the mentally and physically handicapped, and abandoned and neglected children on the five reservations; to consider alternatives for meeting priority needs; and to design and implement facilities and services to meet one or more needs identified. Tribal applications for housing facilities were reviewed and tentatively approved by HUD and HEW in August 1979.

The interagency agreement stipulated that during fiscal year 1980 the Administration for Native Americans (ANA) would provide assistance to the tribes for the development of operational and management plans and the identification of potential funding sources for the services.

To meet the ANA commitment ANA provided a supplemental award of up to $10,000 to the existing ANA grant for each of the five participating tribes.

The Council staff continues to work with the tribes as they move towards the process of entering into formal contract agreements with HUD for construction of the facilities.

INDIAN ACCESS PROJECT

In fiscal year 1979, ANA entered into an agreement with the Administration on Aging to provide support to the National Indian Council on Aging (NICOA) to initiate a demonstration project on a number of Indian reservations for the purpose of increasing the number of elderly Indians receiving cash and other benefits from entitlement programs.

The Administration for Native Americans agreed to provide a sum not to exceed $85,000 per year for up to 3 years to support the demonstration project to increase the receipt of entitlements by elderly Indian people. In fiscal year 1979, ANA transferred $85,000 to the Administration on Aging to provide first year support for the project. In fiscal year 1980, funds in the amount of $100,000 were transferred via memorandum to OHDS budget from ANA to AoA to carry out the second year of the 3-year interagency agreement.

LAGUNA ELDERLY CENTER

During fiscal year 1979, ANA entered into an agreement with the Indian Health Service to jointly provide management assistance, training and technical assistance to the Pueblo of Laguna in the initiation of its elderly center program. The Pueblo of Laguna, located in New Mexico, has developed a program which provides comprehensive health and social services to its elderly population. The project at Laguna includes residential units for the elderly as well as an elderly care facility.

In fiscal year 1979, ANA transferred $20,000 to the IHS to be used for training and technical assistance to the Laguna Elderly Center program. These funds were committed on a one time only basis.

ANA supports the Pueblo of Laguna's effort to automate its financial, vital and informational data needs. ANA encourages and has granted permission to Laguna to revise or redirect its current and future grants to support an automated data processing unit to complement the elderly project. However, no increase in funds is currently available.

ANA ACTIVITIES RELATIVE TO AoA'S TITLE VI PROGRAM

The 1978 amendments to the Older Americans Act established a new grants program under title VI which provides for direct Federal funding to Indian tribes for the provision of social and nutrition services to older Indian people.

The Administration on Aging (AoA) maintained close liaison with the Administration for Native Americans (ANA) throughout the process of policy and regulations development for the implementation of the title VI program. As part of this cooperative effort, ANA assigned a full time staff person to AoA for 3 months in fiscal year 1980 to provide assistance in the regulations development process and to provide a formal linkage between the two agencies. AoA and ANA concurred that this cooperative effort was a significant asset in the development of title VI policy and implementation strategy. The agencies anticipate continuing a close working relationship for the effective coordination of their respective program activities and maximizing the efficiency and impact of program administration.

TITLE XX

The Office of Human Development Services has responsibility for administering the social services programs authorized under titles I, IV–A, X, XIV, and XX of the Social Security Act, as amended. Except for Guam, Puerto Rico, and the Virgin Islands, title XX superseded all of the authorizing titles cited above as of October 1, 1975.

Under title XX, grants are made to States to deliver services under a comprehensive annual services program plan which is designed by each State to meet the needs of that State. At State option services are delivered to individuals whose eligibility is based on income or income maintenance status. States may offer services to persons with family incomes up to 115 percent of the State median family income for a family of four adjusted for family size. However an amount equal to at least 50 percent of the Federal share of State expenditures must be for recipients of aid to families with dependent children (AFDC), supplemental security income (SSI), essential persons or individuals eligible for medicaid. Specified services may also be offered on a group basis. States may choose the services to be provided, as long as each service is directed to at least one of the five title XX goals, and at least three services are directed toward SSI recipients.

A variety of services directed to assisting aged persons to attain or maintain a maximum level of self-care and independence are provided through the social services program. Included are such services as adult day care, adult foster care, protective services, health-related services, homemaker, chore, transportation, and other services that assist elderly persons to remain in their own homes or in community living situations. Services are also offered which facilitate entry into institutional care when necessary.

Since title XX data are collected by service and by category of eligibility of the recipients (e.g. AFDC and SSI), it is not possible to determine precisely total services recipients, and expenditures provided to the elderly. However, data on the number of recipients, and expenditures for services for those older persons eligible for SSI payments is available. The following are reported figures (for fiscal year 1977) and estimates for the number of primary recipients[1] and expenditures for the SSI-aged during fiscal years 1977, 1978, and 1979. Estimates for the number of primary recipients during fiscal year 1980 are not available.

Fiscal year	Number of SSI-aged primary recipients	Expenditures (Federal, State, local funds)
1977	466,000	$255,000,000
1978	451,000	262,000,000
1979	609,000	300,000,000

Since elderly persons other than SSI-aged qualify for, and receive services from each of the services reported, these data understate the total number of elderly recipients and expenditures for services to the aged under title XX. Expenditure increases have been reported for services which are usually associated with the needs of the aged. In particular, community based care services directed toward the title XX goal of preventing or reducing inappropriate institutional care have received increased program emphasis. Universal services such as information and referral, and protective services for adults, as well as group services, have been growing during the last few years. As with all services, these latter services include elderly recipients.

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[1] Primary recipient: An individual with whom, or for whom, a specific goal is established and to whom services are provided for the purpose of achieving the goal. Services are considered to be provided to the primary recipient when they are provided to other members of the primary recipient's family to facilitate achievement of the primary recipient's goal.

As is true of services delivery, research and demonstration projects funded through the Office of Human Development Services tend to address areas in which elderly persons are among the participants in the demonstration programs and may benefit from implementation of the research results.

In fiscal year 1980, we continued projects involved in fiscal year 1978 and 1979. One project, barriers to the development of community based long-term care for elderly and handicapped individuals, particularly emphasizes the elderly. This project is to develop and document methodology for State agency use in identifying barriers to community placements for long-term care.

Another 12 projects deal with such topics as hospice care, social services planning, the impact of Federal policies and services programs on families, transportation to human resource facilities, capacity building of Indian tribal governments to plan and administer comprehensive social services systems, and improved case management systems.

Among the concrete effects of these projects were the funding of a position of a case manager to coordinate social services for the elderly by a local county council on aging; the first national conference on case management; and the development of social services for elderly Indians in two areas. In addition, our transportation projects have established a method for securing insurance coverage for vehicles used to transport the elderly and other vulnerable populations.

SOCIAL SECURITY ADMINISTRATION

PROGRAMS ADMINISTERED BY THE SOCIAL SECURITY ADMINISTRATION

The Social Security Administration (SSA) administers the Federal old age survivors and disability insurance (OASDI) program (title II of the Social Security Act). OASDI is the basic method in the United States of assuring income to individuals and families when workers retire, become disabled, or die. The basic idea of the cash benefits program is that, while they are working, employees and their employers pay earmarked social security contributions (FICA taxes); the self-employed also contribute a percentage of their net earnings. Then, when earnings stop or are reduced because of retirement in old age, death, or disability, cash benefits are paid to partially replace the earnings that were lost. Current contributions are largely paid out in current benefits. However, at the same time, current workers build rights to future benefit protection.

SSA also administers the supplemental security income (SSI) program for aged, blind, and disabled people in financial need (title XVI of the Social Security Act). SSI provides a federally financed floor of income for eligible individuals with limited income and resources. In most cases, SSI supplements income from other sources, including social security benefits.

SSA shares responsibility for the black lung program with the Department of Labor: SSA is responsible, under the Federal Coal Mine Health and Safety Act, for payment of black lung benefits to coal miners and their families who applied for those benefits prior to July 1973, and for payment of black lung benefits to certain survivors of miners.

Local Social Security offices process applications for entitlement to the medicare program and assist individuals in filing claims for medicare benefits. Overall, Federal administrative responsibility for the medicare program rests with the Health Care Financing Administration.

In addition, SSA has Federal administrative responsibility for aid to Indochinese, Cuban, Soviet, and other refugees.

Following is a summary of beneficiary levels today, selected program activities, study groups, social security-related legislation enacted in 1980 and related activities:

I. OASDI BENEFITS AND BENEFICIARIES

At the beginning of 1980, about 94 percent of all Americans age 65 and over were drawing social security benefits or were eligible to draw benefits if they or their spouses retired; about 95 percent of the people who reached 65 in 1980 were eligible for benefits. It is expected that 96 to 98 percent of the aged will be eligible for social security benefits by the end of the century.

At the end of September 1980, 35.4 million people were receiving monthly social security cash benefits (an increase from 34.9 million in September 1979). Of these beneficiaries, 19.4 million were retired workers, 3.6 million were dependents of retired workers, 96,000 were uninsured individuals receiving "special age-72" (Prouty) benefits, 4.7 million were disabled workers and their dependents, and 7.6 million were survivors of deceased workers.

The monthly rate of benefits for September 1980 was $10.6 million compared to $8.9 billion for September 1979. Of this amount, $7.2 billion was paid to retired workers and their dependents, $1.3 billion was paid to disabled workers and their dependents, $2.1 billion was paid to survivors, and $10 million was paid to special age-72 beneficiaries.

Retired workers received an average benefit for September 1980 of $340 (up from $293 in September 1979), while disabled workers received an average benefit of $370 (up from $321). Retired workers newly awarded social security benefits for September 1980 averaged $363, while disabled workers received average initial benefits of $395. During fiscal year 1980 (October 1979-September 1980), $116 billion in social security cash benefits were paid compared to $101 billion in fiscal year 1979. Of that total, retired workers and their dependents received $74.5 billion, disabled workers and their dependents received $14.9 billion, survivors received $25.6 billion, and special age-72 beneficiaries received $121 million. In addition, lump-sum death payments amounted to $381 million.

II. SUPPLEMENTAL SECURITY INCOME BENEFITS AND BENEFICIARIES

In 1980, SSI payment levels (like social security benefit amounts) were automatically adjusted to reflect a 14.3 percent increase in the CPI. Thus, beginning in July 1980, maximum monthly Federal SSI payment levels increased from $208.20 to $238 for an individual, and from $312.30 to $357 for a couple.

During fiscal year 1980, over $7.5 billion in benefits (consisting of $5.7 billion in Federal funds and $1.8 billion in federally administered State supplements) were paid. Of the 4.1 million beneficiaries on the rolls during September 1980, 1.8 million were aged, and 2.3 million receiving SSI based on blindness and disability, although 400,000 of them reached age 65 after they began to get payments. During September 1980, total payments of $695 million were made. The total payments in fiscal year 1980 represent an increase of about $0.9 billion over fiscal year 1979.

III. BLACK LUNG BENEFITS AND BENEFICIARIES

During September 1980, about 404,000 individuals received $83.8 million in black lung benefits which were administered by the Social Security Administration. These benefits are financed from general revenues. Of these individuals, 122,000 miners and their dependents received $45.1 million, while 146,000 widows and their dependents received $38.7 million. The miners and widows had 135,000 dependents. During fiscal year 1980, SSA administered black lung payments in the amount of $1.0 billion.

Black lung benefits increased by 10.1 percent in November 1980 due to an automatic general benefit increase adjustment under the law. The monthly payment to a coal miner disabled by black lung disease increased to $279.80 from $254. The monthly benefits for a miner or widow with one dependent is $419.60, and with two dependents is $489.60. The maximum monthly benefit payable when there are three or more dependents is $559.50.

IV. LOW-INCOME ENERGY ASSISTANCE

Beginning in October 1980, SSA was given Federal administrative responsibility for a program of low-income energy assistance. The purpose of the program was to help low-income individuals avoid serious health and financial crises by providing them assistance to meet the rapidly rising cost of home energy, particularly for heating. Congress appropriated $1.2 billion for the program. Of this amount, $400 million was paid in early 1980 as a special one-time energy allowance to about 3.9 million SSI recipients. (These were all December 1979 recipients except those living in medicaid institutions.) Payments varied by State based on a formula contained in the legislation, and ranged from a low of $34 to the statutory maximum of $250. The remaining $800 million was distributed to the States in the form of block grants. States had flexibility to develop their own programs for distributing the aid, subject to HHS approval. These funds were available to supplement the payments to SSI recipients, and to make payments to persons on other assistance programs or with incomes below 125 percent of the poverty level.

V. OUTREACH

The SSA reorganization of 1979 established the Office of Governmental Affairs which has as one of its principal missions the planning and managing of SSA's "outreach" activities, with the goal of increasing SSA's responsiveness to public concerns about social security programs. Outreach refers to the agency's concerted effort to establish and maintain ongoing, two-way relationships with individuals and organizations inside and outside of government in order to inform them about social security as they inform SSA about their interests. Some of the key elements of the overall outreach strategy are discussed below in the "outreach symposia project" and "implementation of Executive order on consumer affairs."

VI. OUTREACH SYMPOSIA PROJECT

In the period January-June 1980 over 300 town meetings were sponsored by local social security offices throughout the country. These meetings followed a national symposium, ten regional symposia, and a symposium in Puerto Rico in the October-December 1979 period. The series of meetings was designed to help strengthen public confidence in the viability and stability of social security through enhanced public understanding of the present system and current issues.

Over 16,000 persons, including significant representation of the aged, attended these meetings. SSA staff presented basic information on the value of the programs, their content and coverage, how they are financed, and the impact on the programs of changing demographic and social patterns, particularly implications of the changing roles of men and women in society. Participants contributed their views and opinions about the topics presented and social security in general, resulting in a wide variety of thoughts and suggestions to shape the programs in the years to come.

VII. IMPLEMENTATION OF EXECUTIVE ORDER ON CONSUMER AFFAIRS

On September 26, 1979, the President issued Executive Order No. 12160, "providing for the enhancement and coordinating Federal consumer programs," the purpose of which is to ensure that consumer interest is integrated into the decisionmaking processes of government. Many requirements of this order are already ongoing activities of SSA through such functions as: Review of all proposed regulatory and procedural material for adverse impact on the public; identification of problems in existing policy and practices adversely affecting the public; linking interested outside groups with policymakers to ensure consideration of their views before policy is revised; conducting and reviewing the current process for conducting public hearings on proposed regulations; production of informational materials for the public on SSA-administered programs; and the systematic handling of complaints. SSA published its draft Consumer Affairs Plan on June 9, 1980 setting forth the initiatives underway and planned to assure full implementation of the Executive order. The draft was made available to well over 200 groups and organizations for comment. The revised plan has been forwarded to HHS for review and eventual publication in the Federal Register. In the meantime, SSA is continuing to broaden its contacts with the public and is moving ahead to provide the public with greater access to SSA's decisionmaking process.

VIII. INFORMATION AND REFERRAL PROJECT

The broad mission of SSA in the area of income maintenance and social welfare as a result of the HEW reorganization of 1977, has prompted the agency to explore a change in its information and referral policies and practices to meet the needs of this greater and more varied population. In 1979, SSA began an initiative to reassess the agency's role in information and referral for related social and economic services to determine how SSA services can be improved and/or expanded to meet current needs. The effort is aimed at developing processes for referral at the local level based on other agencies' ability to deliver services. SSA is consulting with other government agencies and outside organizations regarding their needs and programs in developing its information and referral plan. This initiative resulted in various proposals to strengthen SSA's information and referral services. These proposals are currently being evaluated within the agency.

IX. IMPROVED COMMUNICATION AND SERVICES

In fiscal year 1980, the Office of Public Affairs undertook the following projects:

Improved Publications

During fiscal year 1980 the Social Security Administration's Office of Public Affairs conducted a comprehensive review of all the administration's public information pamphlets. The objective was to make sure that the information provided to the public was concise, understandable and relevant. A secondary objective was to reduce the total number of publications produced. The revised, redesigned pamphlets will be distributed during fiscal year 1981.

Service to Hispanics

In an effort to improve the overall service to the Hispanic community, the Social Security Administration has translated almost all applications, forms and notices into Spanish for people who indicate a desire to get social security information in Spanish. In addition, the Social Security Administration is now producing publications, radio and television materials specifically designed to reach the Hispanic community.

Improved Notices to Social Security Administration Beneficiaries

The Social Security Administration has redesigned its computer notice system that sends personalized notices to several million working social security beneficiaries each year. Using the information from each beneficiary's annual report of earnings, the system generates a notice which explains how social security benefits are affected by the beneficiary's work and earnings. Each notice has a covering letter which summarizes the benefit changes in a few short paragraphs. Attached to the cover letter is an information sheet that gives more detailed information about how the benefit changes were figured. This notice style gives the beneficiary a simple, easily understood explanation of benefit changes (and for those beneficiaries who want more background, a breakdown of specific benefit facts and figures).

Food Stamp Service in Social Security Administration Offices

In August 1980, Social Security offices began taking food stamp applications from supplemental security income recipients and applicants who live in households where everyone either receives supplemental security income or is applying for it. The Social Security Administration began this service to make it easier for aged, blind and disabled persons to apply for food stamps.

X. SSA ADMINISTRATIVE GOALS AND ACCOMPLISHMENTS

During fiscal year 1980, SSA placed major emphasis on balancing speed and accuracy in the processing of DI, SSI, and RSI claims; improving the processing and recovery of SSI overpayments; working with the States to reduce errors in the AFDC program; and maintaining control over the processing of hearings and appeals in spite of increasing receipts of hearing requests.

These objectives were generally achieved. The gains made in improving processing times during fiscal year 1979 were maintained or improved upon, while accuracy rates were also improved. RSI claims accuracy improved from 95.9 percent at the end of 1979 to 96.3 percent; State agency processing accuracy (medical determinations) increased from 90.6 percent to 93.7 percent in the DI program and from 92.5 percent to 93.2 percent in the SSI program; the amount of unresolved SSI overpayments decreased by 19 percent during 1980; collections increased 7 percent over 1979; and the number of hearing dispositions increased by almost 10 percent over 1979.

Along with these improvements, there were some problem areas. Even though hearings dispositions were up, pending hearing requests increased because of an 11-percent increase in requests for hearing and the inability to hire sufficient numbers of Administrative Law Judges (ALJ's). The SSI payment error rate remained at 5 percent through March 1980. As a result of SSA's concern with the AFDC error rates, a special task force has been established to determine improvements which can be made in this program. Recommendations will be made during fiscal year 1981.

SSA's major emphasis in 1981 is to maintain the processing time and accuracy gains achieved over the past 2 years while implementing the substantial provisions of the disability amendments of 1980. Special emphasis is also being given to assure a smooth move to the new computer center, to improve women and minority work force representation through the equal employment opportunity program, to begin the upgrading of our telecommunications system, to achieve socioeconomic procurement goals and improve management of grants and contracts, to upgrade field office facilities, and to improve systems security.

XI. NATIONAL COMMISSION ON SOCIAL SECURITY

The 1977 amendments established the National Commission on Social Security. Some members were appointed by the President and some by Congress. The National Commission is engaged in a broadscale, comprehensive study of the social security program, including medicare. The study also includes the status of the trust funds, coverage, adequacy of benefits, possible inequities, alternatives to the current programs and to the method of financing the system, integration of the social security system with private retirement programs, and development of a special price index for the elderly. (The Commission issued interim reports on May 11, 1979 and on January 11, 1980. The release of the final report is expected early in 1981.)

XII. PRESIDENT'S COMMISSION ON PENSION POLICY

The President's Commission on Pension Policy was established by Executive order in July 1978. The Commission is examining pension systems around the country in an effort to develop national policies for retirement, survivor, and disability programs that can serve as a guide for public and private programs.

In response to the problems that pension systems face, the President's Commission will:

—Provide an overview of all existing retirement, survivor, and disability programs.

—Assess the ability of existing programs, and systems—encompassing the Federal, State, local, and private sectors—to meet future commitments and future needs.

—Devise a national policy on retirement that can be used as a guide by all programs; and

—Propose reforms that are needed to meet national policy goals, both now and in the future.

The Commission issued interim reports in May and November, 1980; it is expected to submit its final report to the President in February.

XIII. PRECEDENT-SETTING COURT DECISIONS THAT AFFECT THE ELDERLY MADE DURING FISCAL YEAR 1980 OR STILL PENDING

Califano v. *Boles*.—Marriage Requirement—Mothers of Illegitimate Children

On June 27, 1979, the U.S. Supreme Court upheld the constitutionality of the marriage requirements of section (202g) of the Social Security Act. That statute provides for a mother's benefit for a widow or surviving divorced wife of a deceased worker if she has an entitled child of the worker in her care. The Supreme Court concluded that the mothers' benefit was designed to benefit mothers who suffer economic loss upon the death of a worker. To effectuate this, the court determined that the Congress could reasonably conclude that a woman never married to the worker was less likely to be dependent on him at his death than one who was his widow or surviving divorced wife.

Harris v. *Rosario*.—Limitation on AFDC Payments in Puerto Rico

On May 27, 1980, the U.S. Supreme Court upheld the constitutionality of sections 1108(a) and 1905(b) of the Social Security Act. These sections concern Federal medical assistance in Puerto Rico and cause a lower benefit ceiling for Federal programs in Puerto Rico than for Federal programs in the States in the

United States. The Supreme Court held that under the Territory clause of the Constitution, the Congress could treat Puerto Rico differently from the States as long as a rational basis existed. The Supreme Court found such a basis in (1) the increased program costs; (2) the fact that residents of Puerto Rico do not pay Federal income tax; and (3) the possibility of disruption to the economy of Puerto Rico because of increased benefit levels.

O'Connor v. *Harris*.—Gender-Based Classification—Surviving Divorced Father

On September 24, 1979, the U.S. District Court for the Western District of Washington found section 202(g) of the Social Security Act unconstitutional insofar as it provides benefits to a surviving divorced mother with an entitled child in her care, but precludes entitlement to benefits for a similarly situated surviving divorced father. Regulations to effectuate this decision have been promulgated.

Ambrose v. *Califano*.—Gender-Based Classification—Surviving Divorced Husband

On July 17, 1980, the U.S. District Court for the District of Oregon entered a final judgment adjudging unconstitutional the absence from the Social Security Act of provisions for benefits for "surviving divorced husbands." The district court had found application of the Social Security Act unconstitutional to the husband's income, unless this presumption is, in effect, rebutted by the wife. but provides no comparable benefit for a similarly situated male. The district court ordered payment to the plaintiff and what is essentially a nationwide class. Regulations to effectuate this decision are being drafted.

Becker v. *Harris*.—Gender-Based Classification—Allocation of Self-Employment Income in a Community Property Jurisdiction

On July 17, 1980, the U.S. District Court for the Eastern District of California found section 211(a)(5)(A) of the Social Security Act to be an unconstitutional gender-based discrimination. That section provides that self-employment income derived in a community property jurisdiction shall generally be presumed to be the husband's income, unless this presumption is, in effect, rebutted by the wife. The court determined that the statute served no valid "governmental objective" and was "patently arbitrary." Regulations to effectuate this decision are being considered.

Mertz v. *Harris*.—Gender-Based Classification—Widower's Insurance Benefits

On September 10, 1980, the U.S. District Court for the Southern District of Texas entered a judgment finding section 202(f)(1)(A) of the Social Security Act unconstitutional. Section 202(f)(1)(A) requires as a condition of entitlement that a widower "has not remarried." The comparable provisions for widow's benefits, section 202(e)(1)(A), provides a benefit if a widow "is not married." The district court found the challenged provisions to be violative of the "equal protection" clause. If no appeal is taken to the Supreme Court, this decision will be effectuated by regulations.

XIV. SUMMARY OF LEGISLATION ENACTED DURING FISCAL YEAR 1980 THAT SIGNIFICANTLY AFFECTS SSA

Public Law 96-88 (S. 210), Education Organization Act of 1979—signed on October 17, 1979

Establishes a Department of Education, with provisions to transfer to the new department vocational rehabilitation functions and offices vested in HEW. The functions of the Secretary of HEW under sections 222 and 1615 of the Social Security Act are exempted from the provisions of the Act. HEW has been renamed the Department of Health and Human Services.

Public Law 96-110 (H.R. 4955), State Department Migration and Refugee Assistance Appropriations—signed on November 13, 1979

Provides for continuation of the existing Indochinese refugee program at current funding levels from October 1, 1979 through September 30, 1981.

Public Law 96-126 (H.R. 4930), Department of the Interior Appropriations and Energy Assistance Payments to SSI and Low-Income Households—signed November 27, 1979

Includes an SSA-related amendment to fund energy assistance for fiscal year 1980 with a $1.35 billion approproprIation to the Community Services Administration. Of this amount, $1.2 billion was transferred to HHS for payment of energy grants, allowances, and related administrative costs. About $400 million was made available for payment as a special one-time energy allowance to SSI recipients. About $800 million was made available for block grant funding to States for assistance to AFDC, food stamp, or other assistance households, and households with incomes below 125 percent of the poverty level.

Public Law 96-167 (H.R. 5224), Legislation Pertaining to Independent Contractors—signed on December 29, 1979

Extends for 1 more year (from January 1, 1980 to January 1, 1981), the interim relief provided by Congress last year (i.e., forgave all FICA and income tax liability) to businesses that have been treating workers as independent contractors rather than employees.

Public Law 96-178 (H.R. 3091), Tax Treatment of State Legislators' Travel Expenses (Includes Child Support Enforcement Amendment)—signed on January 2, 1980

Continued through March 31, 1980, 75 percent Federal matching of States' costs of providing child support services to non-AFDC clients. Also extended the authority to subsidize childcare employment of welfare recipients.

Public Law 96-212 (H.R. 2816/S. 643), The Refugee Act of 1979—signed on March 17, 1980

Provides a single statutory framework governing the admission and resettlement of refugees; established an Office of Refugee Resettlement within the Department of Health and Human Services; repealed the Indochina Migration and Refugee Assistance Act of 1975; provided 100 percent Federal funding for cash and medical assistance to any refugee during the 3-year period following admission into the United States; provided reimbursement in any fiscal year for 100 percent of the non-Federal cases associated with Cuban refugees to whom SSI payments were being made as of September 30, 1978; and requires the Secretary to report to Congress by January 31 of each year on the status of the program.

Public Law 96-222 (H.R. 2797), Technical Corrections Act of 1979—signed on April 1, 1980

Makes technical corrections related to the Revenue Act of 1978, including conforming amendments concerning earned income tax credits (EITC), pension reform and the Black Lung Benefits Revenue Act. The act is of interest to SSA in that it provides for counting EITC as earned income under the AFDC and SSI programs. It further provides that in cases where an AFDC or SSI recipient receives excess EITC payments which have to be refunded to the Government, the person would receive a corresponding increase in the AFDC or SSI benefit.

Public Law 96-223 (H.R. 3919), Crude Oil Windfall Profit Tax Act of 1979—signed on April 2, 1980

For fiscal years 1981-90, the act sets aside 25 percent of the first $227 billion of windfall profits revenue and one-third of any revenue above that amount to be used for programs for energy assistance to low-income persons.

For fiscal year 1981, the act authorizes $3.115 billion to States for low-income energy assistance programs. Each State will establish and operate, subject to Federal approval, its own plan, but may request SSA to make payments to SSI recipients. Households eligible for the assistance are those receiving AFDC (except foster care); SSI (except households eligible solely on the basis of an SSI recipient who is in a title XIX institution, in the household of another, or in the household a child); food stamps; certain income-tested veterans' benefits; and households with incomes at or below the Bureau of Labor Statistics (BLS) lower living standard.

The funds will be distributed to the States based on allocation formulas in the law. The Secretary shall reserve $2.5 million to be apportioned on the basis of need among the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, Northern Mariana Islands and the Trust Territory of the Pacific Islands and shall transfer to the Community Service Administration $100 million for energy crisis-related activities.

For fiscal years 1982–90, the programs are not specified but rather must be developed and enacted in separate legislation. Of the 25 percent of the projected $227 billion in revenues which are allocated for low-income assistance, for fiscal years 1982–90, the Act does provide a suballocation, as follows:

—50 percent allocated for programs to assist AFDC and SSI recipients under the Social Security Act.

—50 percent allocated to a program for emergency energy assistance.

Public Law 96–243 (H.J. Res. 545), Urgent Appropriation for the Food Stamp Program—signed on May 16, 1980

Made urgent appropriations for the food stamp program for the fiscal year ending September 30, 1980.

Public Law 96–249 (S. 1309), Food Stamp Act Amendments of 1980—signed on May 26, 1980

Increased the fiscal year 1979 authorization and the fiscal year 1980 and 1981 dollar limitations on appropriations for the food stamp programs. The Act also includes provisions to require the Secretary of HHS to provide SSN's and data in HHS files to the Secretary of Agriculture and State agencies for use in the administration of the food stamp program. It also contains provisions to raise the level of deductions for certain medical and dental expenses for purposes of determining food stamp eligibility for residents of households containing an SSI recipient or a member age 60 or over.

Public Law 96–265 (H.R. 3236), Social Security Disability Amendments of 1980—signed on June 9, 1980

Family benefit cap: Family benefits in disability cases are limited to the lesser of 85 percent of the AIME or 150 percent of the PIA, but no less than 100 percent of the PIA. Effective for individuals eligible for benefits after 1978 who were never entitled to disability benefits before July 1980.

Variable dropout years: Dropout years for disabled workers are:

Worker's age:	*Number of dropout years*
Under 27	0
27 to 31	1
32 to 36	2
37 to 41	3
42 to 46	4
47 and over	5

A worker will also get 1 dropout year for each year in which he had no earnings and had a child under age 3 living with him. However, if any year is dropped as a child care dropout year, the total number of dropout years—regular and child care—cannot exceed 3. Effective for individuals who were never entitled to disability benefits before July 1980, except that the child care provision will be effective for monthly benefits after June 1981.

Medicare waiting period: Provides that months in the 24-month medicare waiting period need not be consecutive. Thus, for former DI beneficiaries who become disabled again within a certain time period (60 months for disabled workers and 84 months for disabled widow(er)s and adults disabled since childhood), any months which counted toward meeting the 24-month medicare waiting period will count toward meeting that requirement in the subsequent period of disability.

Extension of entitlement for medicare: Extends medicare for DI beneficiaries (who have not medically recovered) for the proposed 15-month automatic reentitlement period following the trial work period (TWP) and for an additional 24 months.

Work expense deductions: Allows deductions in DI cases of the cost of impairment-related services and devices and attendant care costs from earnings in determining SGA if they are necessary for the beneficiary to work and if the beneficiary pays for them.

Closed evidentiary record: Forecloses the introduction of new evidence in OASDI claims after decisions are made at hearings.

Study of time limits for decisions on benefit claims: Requires the Secretary to report to the Congress by July 1, 1980, on appropriate time limits within which a decision should be made in initial, reconsideration, Hearing and Appeals Council cases under OASDI.

Payment for existing medical evidence: Provides for payment from the trust funds for medical evidence submitted by non-Federal institutions and physicians in DI claims when such evidence is requested and required by the Secretary.

Extension of the term of the National Commissioner on Social Security: Extends the appointments of members of the National Commission on Social Security to April 1, 1981.

Frequency of deposits of social security contributions from State and local governments: Requires that deposits from State and local governments be due 30 days after the end of each month.

Benefits and services for the terminally ill: Provide the Secretary with the authority to participate in a demonstration project being done by HHS on providing services to the terminally ill.

Voluntary certification of medicare supplemental health insurance policies: Establishes a voluntary program to certify medicare supplemental health insurance policies which meet certain minimum standards (so-called medi-gap policies). Issuance of seals of certification is to begin July 1, 1982.

A panel consisting of the HHS Secretary and four State insurance commissioners will be appointed to determine which States are in compliance with the National Association of Insurance Commissioners Model Regulations and have loss-ratios in effect. Effective July 1982 in those States which do not meet standards.

Benefits for people engaging in SGA and exclusion of impairment-related expenses: SSI disabled beneficiaries whose earnings equal or exceed the SGA level will be entitled to special cash benefits until their countable income reached the Federal (or State, if applicable) "breakeven" point. States will have the option of supplementing those entitled under the provision.

People who receive the special benefits will be eligible for medicaid and social services on the same basis as regular SSI recipients.

A blind or disabled person will continue to be eligible for medicaid and social services even if his or her income is at or above the "breakeven" point (and he or she is no longer getting cash benefits) if it is determined, under regulations, that the person:

—Continues to have a disabling impairment.

—Does not have income, except for earnings, which is equal to or in excess of the amount which would cause him to be ineligible for regular or special SSI benefits.

—Would be seriously inhibited in continuing employment through loss of medicaid and social services eligibility; and

—Does not have earnings high enough to allow him or her to provide a reasonable equivalent of the SSI benefits, medicaid, and social services he or she would have in the absence of earnings.

For SSI beneficiaries, impairment-related work expenses will be deductible for substantial gainful activity purposes if paid for by the beneficiary. The deduction is also allowed for benefit-computation purposes. (For purposes of initial entitlement, an individual must meet the income test and qualify for benefits without the deduction.)

Also provides for a 3-year pilot program of grants to States who may, at their option, provide medical assistance (not necessarily under a State's medicaid program) and social services to severely handicapped people engaging in SGA not eligible for SSI, special benefits or medicaid, if the State determines medical assistance and social services are necessary for the individual to keep working. ($6 million authorized for September 1981 through September 1982, with total 3-year expenditures not to exceed $18 million.)

Sheltered workshops: Treats remuneration received in sheltered workshops as earned income for SSI purposes.

Parental deeming: Terminates parental deeming for SSI at age 18. Benefits to recipients who were age 18 or over in September 1980, and who received a supplemental security income benefit for September will not be reduced as a result of this provision.

Aliens under SSI: Provides that income and resources of sponsors will be deemed to aliens for 3 years after entry and aliens will be required to obtain cooperation of sponsors in providing necessary information to SSA. (Exceptions to the deeming provision are provided for: (1) Blind or disabled aliens whose blindness or disability commenced after entry; (2) refugees or aliens granted political asylum.) Makes aliens and sponsors jointly liable for any overpayment during the 3-year period on account of failure to provide correct information to SSA, except where good cause for failure exists.

Continuing DI or SSI benefits for persons in a VR plan: Permits DI and SSI benefits to continue after medical recovery for persons in approved VR programs if SSA determines that the continuance will increase the likelihood that the person will go off the disability rolls permanently.

Automatic reentitlement to disability benefits: Provides that a person may become automatically reentitled to DI or SSI benefits (assuming nonmedical criteria are met) if he stops performing SGA within the 15 months following the end of the trial work period.

Trial work period for disabled widows and widowers: Extends the trial work period to disabled widows and widowers.

Administration of the disability program: Gives the Secretary the authority to establish, through regulations, procedures and performance standards for the State disability determination process. In the event of unsatisfactory State performance, the Secretary could take over the administration of the State determination process. Requires the Secretary to report to Congress by July 1, 1980 on contingency plan for Federal assumption of State functions and operations. Also (1) provides for preferential hiring of State employees (except for the State DDS Administrator or his Deputy), and (2) prohibits HHS from assuming a DDS function until the Secretary of Department of Labor determines that the State has made arrangements to protect State employees not hired by HHS.

Federal review of State agency determinations: Requires the Secretary to review, on a preeffectuation basis, State agency DI allowances. The effective dates for Federal preeffectuation review of title II allowances and continuances would be: 15 percent for fiscal year 1981, 35 percent for fiscal year 1982 and 65 percent for 1983 and thereafter. Title XVI cases will also be reviewed although not mandated in the law.

Also requires the Secretary to implement a program of review of ALJ decisions and submit a report to Congress by January 1, 1982.

Detailed denial notices: Requires that social security and SSI disability denial notices be expressed in language understandable to the claimant and include a discussion of the evidence and reasons why the disability claim was denied.

Limitation on court remands: Permits OASDI cases to be remanded from courts on the Secretary's motion only for "good cause" shown, and on court's own motion only if there is new and material evidence that was not previously submitted and there is "good cause" for not having submitted the evidence. (Provision also would apply for SSI cases since the provision of title II that is amended is referenced in title XVI.)

Payment for certain travel expenses: Provides for payments from the trust funds for travel expenses (with a limit on air travel costs) incident to medical examinations required by SSA in conjunction with a disability or medicare claim and for travel expenses incurred by OASDI and SSI applicants, their representatives and witnesses in traveling to hearings and reconsideration interviews before an Administrative Law Judge. Travel expenses for SSI applicants will be paid from general revenues.

Periodic review of disability determination: Requires that, unless a finding has been made that an SSDI or SSI beneficiary's disability is permanent, the case will be reviewed by the Secretary at least once every 3 years.

Report by the Secretary: Requires the Secretary to submit to the Congress no later than January 1, 1985 a report as to the effects of OASDI and SSI provisions of the bill.

Adjustment of retroactive title II benefits on account of SSI benefits: Provides for adjusting retroactive title II social security benefits by the amount of SSI benefits already paid that would not have been paid if the social security benefits had been paid, and therefore taken into account as income, on their regularly scheduled payment dates.

Demonstration authority: Requires the Commissioner to conduct demonstration projects and experiments to test effect of substantial gainful activity (SGA) alternatives on attempts to return to work and to report the findings by January 1, 1983.

Authorizes waiver-of-benefit requirements of the disability insurance and medicare programs to permit demonstration projects to test ways to stimulate disabled people to return to work. An interim report on the project must be sent to Congress by January 1, 1983 and a final report 5 years after enactment.)

Authorizes waivers in the case of other DI demonstration projects which SSA may wish to undertake, particularly rehabilitation projects.

Also provides SSA general experimentation authority in the SSI program with the following qualifications: (1) Participation must be voluntary; (2) total income and resources of a person must not be reduced as a result of an experiment; and (3) there must be a project to ascertain the feasibility of treating drug addicts and alcoholics to prevent permanent disability.

Work incentive program: In addition to registration requirements under current law, adds a requirement that AFDC recipients not exempted by law must register for and participate in employment search activities in the WIN program as a condition of AFDC eligibility; provides to registrants additional social and supportive services necessary to find and retain employment.

Allows States to match Federal WIN funds with in-kind goods and services.

Provides for locating employment and supportive services together.

Eliminates required 60-day counseling period in termination of assistance.

Authorizes Secretaries of HHS and Labor to establish the period during which individuals will continue to be ineligible for AFDC if they refuse without good cause to participate in the WIN program.

Clarifies that earned income from public service employment (PSE) is not disregarded in computing AFDC benefits.

Provides a limitation of 8 weeks per year on employment search activity and requires reimbursement of employment search expenses.

Use of IRS to collect child support for non-AFDC families: Extends IRS child support collection authority to non-AFDC child support enforcement cases, subject to present law certification and other requirements.

Safeguarding information: Exempts any governmental agency, or component or instrumentality thereof, authorized by law to conduct audits or similar activities in connection with the administration of the AFDC program from the general prohibition against disclosure of personal information about AFDC recipients to legislative bodies. The amendment makes similar changes with regard to audits under title XX, social services.

Federal matching for child support duties performed by court personnel: Allows Federal matching for State expenditures (including compensation) for court personnel (less payment of judges' salaries and other officials making judicial decisions, e.g., magistrates) and other supportive and administrative personnel for title IV–D functions, to the extent the expenses exceed State expenses for the same activities for calendar year 1978.

Child support management information systems: Increases Federal matching to 90 percent for title IV–D costs incurred by States in developing and implementing computer information systems; requires HHS assistance and review of State systems.

AFDC management information systems: Increases the current 50 percent Federal matching to 90 percent for title IV–A costs incurred by States in developing, designing, and installing computer information systems and retains the current 50–50 matching for operational costs.

Child support reporting and matching procedures: Prohibits advance payment of the Federal share of State title IV–D administrative expenses for a calendar quarter unless the State has submitted a complete report of the child support collected and disbursed in the quarter which ended 6 months earlier; allows reduction in the payment to a State of title IV–A monies by the Federal share of title IV–D collections made but not reported by the State.

Access to wage information for child support program: Authorizes the Commissioner of Social Security to disclose wage, self-employment and retirement income records for title IV–D purposes to State and local child support agencies, with stringent safeguards. Also permits State unemployment compensation information to be released to child support agencies.

Public Law 96–272 (H.R. 3434), Adoption Assistance and Child Welfare Act of 1980—signed on June 17, 1980

Transferred the current title IV–A, AFDC foster care program to a newly created part E of title IV, "Federal Payments for Adoption Assistance and Foster

Care." States may shift AFDC foster care from title IV–A to the new title IV–E program as of October 1, 1980 and are required to have made the transition by October 1, 1982. The new law removed the limitation, with certain conditions, that children must be placed in foster care as the result of a judicial determination in order to receive foster care payments. It also authorized Federal matching for adoption assistance payments to parents who adopt children eligible for AFDC or SSI with "special needs." A ceiling of $2.7 billion for fiscal year 1980 was placed on Federal title XX funds. This amount will be increased annually thereafter.

With respect to the AFDC, SSI and CSE amendments the law provides that:

—AFDC earnings disregards will not be applied to any earned income not reported on a timely basis.

—States will be permitted to prorate the shelter and utilities portion of the AFDC benefit when the AFDC household includes ineligible, closely related relatives.

—States must file claims for Federal reimbursement under the AFDC, SSI, medicaid and other Social Security Act programs within 2 years after expenditure (with certain exceptions).

—Federal matching will be allowed for AFDC foster care children voluntarily removed from the home of a relative prior to a judicial determination when such a determination (made before October 1, 1978) subsequently found the action to be in the best interest of the child.

—The $30 million annual Federal funding for the services programs administered by States for disabled and blind children receiving SSI shall be extended to September 30, 1982.

—AFDC and SSI recipients eligible for higher VA pension benefits under the 1978 VA pension improvements legislation, and living in States which provide medicaid eligibility for AFDC and SSI recipients only on a categorical basis (i.e., States which do not have programs for the medically needy), may refuse to accept the higher VA pension in order to continue eligibility for SSI, AFDC and medicaid.

—The 75-percent Federal matching for the non-AFDC child support enforcement program that was reinstated by Public Law 96–178 was made permanent.

—The fiscal year 1979 temporary increase in the ceiling and matching rate for AFDC and aid to the aged, blind and disabled in the territories was made permanent. The new ceiling is $77.7 million with a matching rate of 75 percent.

—A 15-percent incentive payment financed entirely from the Federal share of collections shall be made to States which enforce and collect child support within the State on their own behalf.

—The imposition of the 5-percent penalty for failure by a State to have an effective child support enforcement program for the period January 1, 1977 to October 1, 1977 was delayed until October 1, 1980.

Public Law 96–321 (S. 2995), Heat Crisis Program—Signed on August 4, 1980

Permitted the Community Services Administration to reprogram $21 million from its rural developments' unspent funds under the energy crisis assistance program to help low-income individuals meet the cost of heat crisis-related energy bills.

Public Law 96–354 (S. 299), Regulatory Flexibility Act—Signed on September 19, 1980

Contains provisions concerning agency rulemaking requirements which require an agency to:

—Assess the economic and paperwork impact of a proposed rule on individuals, small businesses, organizations and governments; and also require that such assessment include possible alternatives to the proposed rule.

—In addition to current information required at the time of publication of a notice of proposed rulemaking, include: (1) A description and estimate of the number of entities to which the proposed rule would apply: (2) identification of duplicative or overlapping rules; (3) agency assurance to consider acceptable alternatives to the proposed rule; and (4) statements outlining the purpose, form and length of recordkeeping and reporting forms and skills needed to complete same, estimate of personnel required for recordkeeping purposes, and estimate of time required for compliance for the entities.

Public Law 96–364 (H.R. 3904), Multiemployer Pension Plan Amendments Act of 1976—Signed on September 26, 1980

Contains a social security-related provision to provide that the unemployment pension offset requirement of existing law (section 3304(a) 15 of the Internal Revenue Code) shall continue to apply in the case of social security and railroad retirement benefits. The law also authorizes States to limit the amount of pension offset to take account of the individual's contributions to the retirement benefit.

HEALTH CARE FINANCING ADMINISTRATION

LONG-TERM CARE STUDIES AND DEMONSTRATIONS

The mission of the Health Care Financing Administration (HCFA) is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 45 million aged, disabled, and low-income Americans. HCFA is committed to making beneficiaries aware of the services for which they are eligible, promoting the accessibility of those services and ensuring that HCFA policies and actions promote efficiency and quality within the total health care delivery system.

HCFA's programs are the principal source of funding for long-term care services in the United States, primarily skilled nursing and intermediate care facilities, and home health care services. HCFA spent an estimated $8.2 billion in Federal and State funds for long-term care services in fiscal year 1979. The medicaid program financed the greatest part of these expenditures, with Federal and State payments of over $7 billion for skilled and intermediate care nursing facility services, and an estimated $248 million for home health care services. (The medicare program spent approximately $368 million for skilled nursing facility services and $445 million for home health services in fiscal year 1979). Since 1970, nursing home care expenditures have experienced annual increases averaging 16 percent. In addition, during that period, nursing home days of care increased from 4 to 6 percent annually. The increased utilization of institutionalized long-term care services may be attributed in part to the growing population at risk. Today, about one-fourth of the elderly population is 75 and over. However, this proportion is projected to increase by over one-third by the year 2035. The 85 and over age group will represent 1 of every 10 elderly persons by the year 2035. The data indicates that currently three-fourths of all nursing home residents are 75 and over, and more than one-third are 85 years and older.[1] However, the aged are only one segment of the long-term care population.

The adult disabled constitute a substantial element of the population with long-term care needs. Approximately 23 percent of the population over the age of 18 have at least some limitation to their physical functioning.[2] Data have also been reported which indicate that the number of adult disabled under age 65 who have severe impairments is equal to the number of impaired persons over 65.[3]

Still another segment of the long-term care population are the mentally retarded and developmentally disabled. Developmental disabilities are defined as those conditions attributable to mental retardation, cerebral palsy, epilepsy or other related conditions. Mental retardation is defined on the basis of IQ as well as adaptive behavior. Recent estimates set the number of mentally retarded persons of all ages in the United States at 6 million, of whom 670,000 are diagnosed as severely handicapped. Of the remaining developmentally disabled population, 580,000 are estimated to have cerebral palsy, 206,000 are epileptics, and 600,000 with other neurological disorders including muscular dystrophy and speech and hearing disorders.[4] Within this segment of the long-term care population alone, there are several levels of impairment—from the profoundly retarded who require total and constant care, to the moderately retarded who might be able to manage some personal tasks with supervision, to the mildly retarded, who are often able to care for themselves and hold jobs. This latter subgroup are often able to live in a sheltered environment or alone.[5]

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[1] "Some Prospects for the Future Elderly Population," Statistical Reports on Older Americans, AoA, HEW, January 1978, p. 3.

[2] Final Report, "National Long-Term Care Project," University of Chicago, Center for the Study of Welfare Society, August 1980 (unpublished), p. 11.

[3] LTC for the Elderly and Disabled, Budget Issue Paper, CBO, February 1977, p. ix.

[4] "Long Term Care, A Challenge to Service Systems," Judith LaVor; "Long-Term Care," Praeger 1979, pp. 22 and 23.

[5] LaPorte and Rubin, "Long Term Care," Praeger 1979, p. 1.

The adult chronically mentally ill make up another growing portion of the long-term care population. Mental disorders affect up to 15 percent of the population in the United States during any given year.[6] The President's Commission on Mental Health reports that the direct cost of mental health services in the mid-70's exceeded $17 billion per year representing 12 percent of total national health care expenditures. In addition, the mentally ill have higher than average rates of physical illness, using medical services at almost twice the rate of the nonmentally ill population.[7] Primary diagnosis data from 1976 and 1977 reveal that 800,000 mentally ill people were residents in nursing homes during that time. This accounts for upwards of two-thirds of the total nursing home population.[8]

HCFA's Office of Research, Demonstration and Statistics (ORDS) has the responsibility for conducting long-term care research and demonstrations. The Long-Term Care Division of Experimentation within ORDS has been especially interested in supporting research and demonstrations which include the following areas:

DEMONSTRATIONS

(1) Organization and delivery of long-term care services at the State or community level, including management of services by providers, new configurations of service settings and management of the service needs of individuals.

(2) The provision of service packages to determine what packages of health and social services are most appropriately funded by the patient, private insurance, welfare-based programs or social insurance at the State and Federal level.

(3) Innovative reimbursement methods which would test new ways to pay providers of services in order to promote cost-effectiveness and the development of added services in areas of identified need.

(4) Test the impact of changes in the current methods of regulating quality of care in institutional and community settings.

(5) Testing financing of services with private insurers or HMO's to determine whether a health care benefit can be designed to include sufficient support services to maintain the aged and the disabled in the least restrictive, most cost-effective setting.

RESEARCH STUDIES

(1) Economic and reimbursement analyses which would include economic analyses of the home health industry, analyses of the influences of funding patterns on the availability and use of services, and studies of the economics of the insurance industry regarding long-term care.

(2) Patient characteristics and service use of residents in long-term care settings other than nursing homes; such as domiciliary care facilities. After an analysis of the available data, it may be deemed necessary to conduct a survey of those facilities and their residents for the purpose of comparative analysis with nursing homes.

(3) Analyze the role of families in the provision of care. This area would include programs providing home-based care, and/or the relationship between family roles and publicly provided services.

RESEARCH AND DEMONSTRATION ACTIVITIES

GENERAL SUMMARY

Research and demonstration projects are underway to examine the effects of revising benefits and eligibility criteria which currently place restrictions on admissions to nursing homes and hospices, often producing system inefficiencies. Studies and demonstrations are being conducted to assess the impact of new reimbursement strategies to promote cost containment and foster quality of care. Efforts are also underway to identify more effective long-term care quality assurance techniques and to improve the statistics and baseline information upon which future assessment of needs, problem identification and policy decisions will be based. A number of demonstrations are aimed at the development of community-based and in-home delivery systems for long-term care services. These projects focus on the coordination and management of an appropriate mix of health and social services directed at individual client needs.

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[6] Archives of General Psychiatry, June 1978, vol. 35.

[7] Services D. No. 5. Mental Disorder and Primary Medical Care, Analytical Review of the Literature, 1974, National Institute of Mental Health.

[8] Services for the Chronically Mentally Ill. The Implications of Financing. Unpublished paper (Wallack, 1979).

DEMONSTRATIONS

Individual Projects—Ongoing

Community Care Demonstrations

New York, Monroe County I

The New York State Department of Social Services is conducting a demonstration project under the authority of section 1115 of the Social Security Act, through the Monroe County Long-Term Care Program, Inc. (MCLTCP). The purpose of this project is to demonstrate alternative approaches to delivering and financing long-term care to the adult disabled and elderly medicaid population of the county.

The project has developed the assessment for community care services (ACCESS) model as a centralized unit responsible for all aspects of long-term care for Monroe County residents, 18 years of age or older, who have long-term health care needs, and who are eligible for medicaid benefits. Program responsibilities include developing and coordinating community services, administering long-term care funds, approving all public payments for institutional and community long-term care services, and collecting program data. ACCESS staff provides each client with a comprehensive needs assessment, assistance in planning and obtaining community or institutional services, and ongoing monitoring of the appropriateness of the services. All long-term care services provided under medicaid in the county must be coordinated with the ACCESS unit in order for the provider to be reimbursed. Private pay patients may voluntarily use ACCESS services.

ACCESS assessment activity varies based on client location (e.g., acute care facility or in the community). However, actual assessments are all carried out by using the preadmission form (PAF) developed by the project to improve upon previously utilized State forms which attempted to document patient condition. The principal focus of the PAF is to determine client's capacity for self-care and to determine specific service needs necessary for the patient to remain at home, if at all possible. Assessments are carried out by the community health nurse (CHN) from the county health department or the Visiting Nurse Service of Rochester (VNS).

Once a patient's need have been determined, the assessor completes an alternate care plan (ACP) form which provides a detailed home care package, including identification of service, personnel needed and equipment necessary for home care. On the basis of the ACP, ACCESS determines the cost and practicality of home care for the patient. If the patient and family agree to the service plan, steps are taken to initiate services for the client (whether it involves home care or admission to a long-term care facility). As part of its contract with the County Division of Social Services, ACCESS may only approve home services for medicaid clients who can be assisted in home care for less than 75 percent of the cost of a comparable level of care in an long term care facility. If costs exceed 75 percent, ACCESS must make a special request to the DSS to allow home services. Nonmedicaid patients (e.g., private pay voluntary participants) must arrange for payment of their services on their own, although ACCESS will assist and advise them in these arrangements.

ACCESS provides followup to its client population by a home review system. Home review visits are made three times a year for medicaid clients and where necessary and agreed to by nonmedical clients.

Utilization review forms are routinely shared with ACCESS by three church sponsored nursing homes and one public facility in the county for all required review periods (i.e., 30, 60, and 90 day review) determines whether the patient is at the appropriate level of care. If the UR form indicates a change may be necessary, the Genesee Valley Medical Foundation (that conducts the utilization reviews) transmits the form to ACCESS for review and resolution.

Section 1115 medicaid waivers permits the project to include the following services: Friendly visiting, housing improvement, home maintenance/heavy chore services, housing assistance, transportation, moving assistance, and respite care.

The project has the authority to contract with providers for the delivery of services. After bills are submitted to the project by providers, their claims based on State medicaid reimbursement schedules are forwarded by the project to the State medicaid office for payment.

Objectives.—The objectives of the project are:

—To provide long-term care services which are appropriate, cost-effective, and acceptable to the client.

—To provide coordination and continuity of case management for long-term care clients.

—To improve long-term care assessment and review procedures.

—To collect data about needs, service utilization, and appropriateness of placement of persons requiring long-term care.

—To reduce the number of county residents who are in acute hospitals and long-term care institutions.

—To reduce per person rate of increase of medicaid expenditures for individuals needing long-term care below the rate that would have occurred had the project never existed.

In the initial 24 months of ACCESS activity, 6,451 referrals were received; 3,430 from hospitals and 3,021 from community sources. The community referrals came from home health agencies (29 percent), clients and/or families (29 percent), long-term care facilities (11 percent) local human services agencies (5 percent) and physicians (5 percent). During that time a total of 4,433 clients were processed through the assessment stage and were either set up with a package of home services or admitted to a long term care facility. Of the 4,433 clients who were processed into the system, 63 percent were at home and the others admitted to a facility.

Medicaid costs for all direct, noninstitutional services for the 835 skilled level patients who were assessed at home under the ACCESS system, is estimated to be $23.38/day, or 52 percent of the comparable medicaid institutional rate (at $45/day). The medicaid cost for health related and proprietary home level service packages are also reported to be less than half of the comparable institutional rate.

Preliminary data show that home care costs for long-term care patients under the demonstration are from 30 to 50 percent of the county's comparable institutional costs. Skilled nursing services provided in the home through the project were estimated to be $20.01 per day compared to $45 per day for equivalent institutional care. For health-related services (equivalent to ICF care), the costs were $9.08 for home care as compared to $27 for institutional care. At the domiciliary care level, the costs were $4.21 compared to $16 at the institutional level.

New York, Monroe County II

The delivery model used for the section 1115 Monroe County long-term care medicaid project (Monroe County I) will be expanded under the authority of section 222 of the Social Security Act to include case management and patient assessment services for the county's *medicare* population in need of long-term care. This demonstration shares the purpose and goals of the section 1115 *medicaid* project. The addition of this project to the Monroe County program will enable the county to work toward an integration of medicare and medicaid long-term care services in the county and to simplify administration.

In addition to the ACCESS process described for the Monroe County I project, section 222 medicare waivers will enable this project, approved in July 1980, to implement a utilization review component whereby once a client has entered a facility or has been approved for home care, a set review schedule will be used. Medicare entitled clients will be reviewed in a skilled nursing facility every 14 days by a utilization review nurse from the Genesee Valley Medical Foundation. Medicare entitled clients at home will be reviewed by a nurse from a certified home health agency every 28 days. In addition, the section 222 medicare waivers will permit ACCESS to certify a client's need for skilled nursing services for up to 14 consecutive days in a skilled nursing facility, and up to 28 days for the provision of home care services, if approved by the client's private physician.

The waivered medicare services under this demonstration include: client intake and assessment; noninstitutional skilled nursing facility services; financial counseling; in-home architectural review; and transportation services. Extended care services will be furnished to participating skilled nursing facilities (SNF's) if the patient requires daily skilled nursing or other skilled rehabilitation services which can only be provided in a SNF on an inpatient basis. The "post-hospital" medicare requirements for SNF care and part A home health care are also waived in order to implement this project.

This project is scheduled to begin operations in May 1981.

New York State, Long-Term Home Health Care Program—Nursing Home Without Walls

The New York State long-term home health care program (LTHHCP), also known as the "nursing home without walls" program, was established by the State legislature to become effective April 1, 1978. The program provides for a voluntary alternative to institutionalization for medicaid clients who meet the medical criteria for skilled nursing facilities (SNF's) or intermediate care facilities (ICF's). A maximum expenditure for home care has been set at 75 percent of the going rate in a locale for SNF or ICF levels of care for which the client is eligible.

The New York State Department of Social Services received medicaid waivers in September 1978 under section 1115 of the Social Security Act to assist in a 3-year demonstration of the gradual implementation of the program.

The purpose of the program is to reduce fragmentation in the provision of home care services to the aged and disabled through a single entry system which coordinates and provides these services in nine sites throughout the State. The sites are based on a single entry system which coordinates and provides all of the services. The objectives of the project include: (1) Maximizing the use of available resources; (2) determining whether various types of providers are differentially successful in providing these services; (3) comparing the effectiveness of long-term care programs in different geographical areas; (4) comparing the program with traditional home health care provided by certified agencies; and (5) promoting cost containment.

As illustrated below, each of the nine sites show a different pattern in development of their respective patient caseloads.

Sites	Operational date	Current caseload [1]	Capacity
Bronx, Montefiore Hospital	August 1979	32	100
New York City, St. Vincent's Hospital	September 1979	30	80
Queens, Visiting Nurse Service	May 1980	45	75
Brooklyn, Metropolitan Jewish Geriatric Center	May 1979	133	155
Buffalo, 24 Rhode Island St. Nursing Home Co., Inc. N.Y.C.	November 1978	35	50
Buffalo, Erie County Department of Health	September 1979	32	105
Syracuse, Visiting Nurse Association of Central New York	March 1979	40	100
Syracuse, Onondaga County Department of Health	March 1979	72	120
Olean, Cattaraugus County Department of Health	April 1979	23	20

[1] As of the end of November 1980.

Under the LTHHCP, all patients must be medicaid eligible in need of either SNF or ICF levels of care. For all potential program users, a medical assessment abstract must be completed which produces a prediction score, referred to as the DMS-1 score. The DMS-1 assessment instrument is used in New York State as a tool to determine the appropriate placement of patients in long-term care facilities. When patients are determined to be eligible for the LTHHCP program a joint in-home assessment is completed by an LTHHCP nurse and a caseworker from the local (State) social service district. Following completion of the assessment, a plan of care is developed and a budget review is initiated by the caseworker. This budget review determines whether the total projected costs are within 75 percent of the monthly average medicaid costs of the going rate for SNF or ICF levels of care for which the client is eligible. A reassessment is conducted every 120 days and a physician review of patient care needs is renewed every 60 days.

The coordination of the services and the case management functions are shared by the LTHHCP coordinator and caseworker. Professional support must be available to patients through an emergency on-call system 24 hours a day.

In the initial startup phases, the State Department of Social Services and Health Systems Management together with Senator Lombardi (the author of the LTHHCP legislation), met with local commissioners in each district site to familiarize them with the program and facilitate programs implementation. In addition, the State met with hospital discharge planners to make them aware of the program and worked with the local social service districts to train staff and provide technical assistance to the LTHHCP staffs. However, the project experienced some difficulties in becoming fully operational. Startup was delayed as a result of staff turnover, problems in coordination and site difficulties in obtaining referrals. There was also a delay in the enactment of State legislation authorizing financial participation for reimbursement of the seven waivered services under the section 1115 demonstration authority. The implementation and payment mechanism for these services is currently under development by the State and will be released shortly. The waivered services are: home maintenance, nutrition counseling/educational services, respiratory therapy, respite care, social day care, transportation, congregate meal services, moving assistance, housing improvement services, and medical-social services. For evaluation purposes, the project will also conduct primary data collection on a comparison population for analysis by Abt Associates, Inc. (the HCFA evaluator).

The project has acted to resolve some of its problems with three additional State monitoring staff positions to provide site assistance and is working with the evaluator in coordinating and developing the data collection strategy. Because there have been delays in the joint assessment process to determine patient eligibility, an "alternative entry procedure" was established, which allows the provider to begin service to the patient immediately based on their own initial assessment of the patient. A joint assessment is then conducted with the local social service district.

In the New York City area, where there are four sites, a long-term care task force has been established with participation from the sites and the New York City Human Resources Administration to facilitate communication and coordination of efforts in program implementation.

In addition, it is anticipated that the following legislative modifications passed by the State legislature in June 1980, will enhance project operations:

(1) Reallocation of patient slots among the nine approved sites through a change in the State hospital code and legislation authorizing the commissioner of health to stipulate the maximum number of persons that an LTHHCP may serve.

(2) Passage of a Senate bill will annualize the 75 percent cap so that if it is reasonably anticipated that average expenditures for a year's time will not exceed the cap, the patient can be admitted to the program.

(3) Legislation that amends the eligibility requirement in the LTHHCP program. This will require that the patient be "medically eligible" for placement in a residential health care facility.

Oregon, FIG Waiver Continuum of Care Project for the Elderly

The Oregon Department of Human Resources was awarded a grant in September 1979, to test the provision of alternate community-based services to the elderly in a five-county area in the southwestern part of the State. This demonstration was funded for the first year of a 3-year project under the authority of section 1115 of the Social Security Act. The project has also received a grant from the Administration on Aging to support administration costs and an evaluation component for the project.

The two components of the project—FIG (flexible intergovernmental grant) and section 1115 waivers share the same objective: to serve the elderly more appropriately and contain medicare costs. The FIG component most directly addresses service delivery deficiencies due to uncoordinated, unintegrated service delivery by diverse agencies serving the elderly. The waiver component addresse fiscal imbalance in the service system due to Federal funding patterns which encourage maximum utilization of medicaid institutionalization. Each componen utilized separately will impact both problems to some extent; however, use o both of the components together in one of the five counties should maximize th impact on deficiencies in the current system.

The five sites and their respective research conditions are: Jackson Count (FIG and waiver), Josephine County (FIG only), Coos/Curry counties (waive only), and Douglas County (comparison).

In carrying out this demonstration, a cost containment model was developed t address the problems involved with a statewide multiple entry service deliver system without changing any of the State agency's internal structure. Uniqu features of the project are: (1) Accountability and decision making assigned t a county policy committee; (2) a profile of all provider agencies serving the elderly to be distributed to each participating provider; (3) the use of a common functional assessment tool to standardize placement choices. Each site is conducting assessment and reassessment; care planning, and case management with followup by currently employed county personnel.

The State project is targeted to individuals 65 years or older who are eligible for medicaid and title XX benefits and have been assessed as eligible for in-home services instead of nursing home placement.

Certain health-related and social services which are not otherwise provided under title XIX are provided under waiver authority in the waivered counties. These include: Homemaking and housekeeping services, chore services, home delivered meals, adult foster home services, adult residential services, and limited transportation services.

The specific objectives of FIG are:

—To overcome fiscal imbalance and service delivery deficiencies in current title XIX program.

—To achieve cost containment.

—To provide alternative community based service to elderly persons to delay or prevent institutional placement.

—To provide more appropriate in-home health services without increasing current fiscal resources allotted to institutional and in-home titles XIX and XX program components.

The basic patient assessment instrument utilized by the project is known as the placement information base (PIB), which was developed by the State prior to the current demonstration. Although shorter than most instruments currently being used in demonstration projects, the PIB contains the important items that provide information on which a decision to maintain a person in his own home can be made. The items are organized to obtain pertinent information regarding an individual's ability to communicate, to ambulate, to manage his living environment, to perform both activities of daily living (ADL) and instrumental activities (IADL), and to handle financial affairs. The instrument has undergone a number of revisions and has been expanded and is currently being used statewide for adult services. This instrument is used by county agency personnel, by providers (for referrals made to the project) and by project staff. A training program has been developed for all project staff to assure uniform application of the expanded assessment instrument in the five-county area. The project became operational in January 1980.

As of September 1980, the caseload in the five-county area was 1,002. The project results to date in the FIG only and the FIG/waiver counties are similar. Both counties have shown consistent reductions in expenditures of medicaid funds for nursing home care. It appears that the FIG component continues to have significant impact on the long-term care system in both counties. Results in the waiver only and the comparison counties tend to reinforce the tentative conclusion that local agency cooperation and planning toward the goal of preventing or delaying nursing home placement is vital to impacting nursing home utilization.

The provision of additional financial resources (e.g., waivers) without other intervention (e.g., FIG component) has not significantly impacted nursing home growth in the four counties involved in the project.

A report on the first operational year of the project will be available in the spring of 1981.

San Diego, North San Diego County, Long-Term Care Project

The purpose of this demonstration is to compare client benefits and costs of care between existing long-term care services and those provided under the project. The project will provide a comprehensive, coordinated system of long-term care for medicare beneficiaries aged 65 and over. The hypothesis to be tested is that a coordinated system of long-term care service delivery for medicare beneficiaries 65 and over, providing continuity of care with a wide array of in-home, community-based, and institutional resources, stressing client education for self-care and client participation in care plan development, will result in clients achieving and maintaining optimal health status and functional independnce and will assist in containing the overall costs of health care.

In designing the demonstration, the project established broad goals: (1) To demonstrate that a medicare-certified provider of home health services with a range of supplementary in-home supportive services, and an established system of communitywide linkages, is an appropriate and cost effective resource for the administration of a long-term care system; (2) to assist the frail elderly, chronically ill, and disabled persons 65 and over to achieve and maintain an optimum level of health, self-care and functional independence in their own homes and cultural environment; (3) to assure appropriate and acceptable out-of-home placement only after a thorough exploration of personal and community resources demonstrates that needs cannot be met at home.

The project builds upon the existing scope of medicare covered home health services provided by the Allied Home Health Association and the Visiting Nurse Association. Through this delivery model the project links an existing information and referral network with a centralized single entry system. The project services include: professional assessment of client needs, client participation in care plan formulation, and case management. The project contracts with providers for delivery of services.

The project will provide the following services under the Section 222 waiver authority: Adult day health care, home delivered meals, homemaker services, escorted transportation, patient educational services to enable the patient to follow the physician's instruction for self-care, and professional staff visits to monitor the patient's functional status.

Approximately 500 experimental and 250 control participants are expected to be enrolled in the project.

During this first developmental year; a patient assessment instrument which has been used by the Allied Home Health Association since 1977, was revised for use by this project to include items of broader scope. The instrument provides four levels of information regarding patterns of service utilization: (1) Patient assessment; (2) services of existing community providers; (3) services provided by the patient's informal support system; and (4) medicare-waivered services specific to the long-term care project.

The project has trained the initial assessment teams, who include staff of the San Diego Visiting Nurse Association as well as project staff. In addition, special training has been provided for project nurses and social workers in the area of care planning and case management.

The project has obtained commitment of local service providers and referral sources. It is estimated that the project will be fully operational by February 1981.

Connecticut, Triage

The Triage model is based upon a single entry access point to the health delivery system for elderly persons. The demonstration project tests the feasibility and effectiveness of service coordination for elderly and disabled individuals living in a seven-town area in central Connecticut. The project is designed to build an appropriate interface between client and multiple service agencies, whereby care is organized around the client and the available resources.

Triage was initiated by the State of Connecticut in 1974, with State funding and a grant from the Administration on Aging and in 1975 received section 222 medicare waivers together with funding from the National Center for Health Services Research, Public Health Service, for the research component of the project. These initial years of the project are referred to as Triage I.

On April 1, 1979, HCFA approved a 2-year project utilizing the same demonstration and research design in order to obtain needed longitudinal data regarding the utilization and cost of services provided to this group of patients from the inception of the project. This 2-year project is known as Triage II.

The project serves an eligible population of 19,526 people, 65 years and over who are entitled to medicare parts A and B and who has developed its service delivery system around individual needs, rather than tailoring the care to existing reimbursable sources. The delivery model includes the following features: patient assessment and individualized plans of care, coordination of all available health related services, creation of new services in the demonstration area, monitoring of the plans of care, and evaluation of pertinent data in accordance with a research design so that patient outcomes and costs of services can be available for study by health care planners.

The project serves 1,500 participants; 300 of which are experimentals and 195 are controls for research purposes.

The objectives of the project are: To increase effectiveness of health services, and to develop necessary preventive and supportive services and demonstrate their value to target population.

To provide single entry assessment mechanism to coordinate delivery of institutional, ambulatory, and in-home services which will result in cost containment.

To demonstrate the effectiveness of coordinated care, including: (a) Care to prevent illness, compensate for disability and support independent living at home; (b) care prescribed appropriate to need rather than according to third-party payor service restrictions; and (c) use of professional nurse-clinician/social service coordinator teams to assess needs of individuals, arrange for appropriate services and provide case management services.

To reduce expenditures for health care delivered to target population.

The Triage model operates through a clinical process of care developed and monitored by interdisciplinary teams, each of which consists of a nurse-clinician and a social service coordinator (social worker). The clinical process of care includes the following four stages:

(a) *Referral.*—Most frequent sources of referral have been self-referral, family, friends, visiting nurses, hospital discharge planners, physicians and social workers.

(b) *Assessment.*—The nurse-clinician/social service coordinator team jointly visit the client's home to fully assess client needs, using a comprehensive assessment form. This form was developed and refined by project clinical staff, the project research team, and a geriatric physician consultant. The assessment consists of a modified physical examination, and an extensive interview. The interview includes a complete health history, information on client functional status, nutrition, physical environment and living expenditures. Functional status is assessed by the use of three standardized instruments—the Activities of Daily Living (Katz, et al.), the Instrumental Activities of Daily Living (Lawton and Brody) and the Mental Status Questionnaire (Goldfarb, Kahn, et al.). This process provides the data base upon which the plan of care is developed for each client.

(c) *Coordinating the care plan.*—Based on the assessment data, a plan of care is developed. The Triage team works with the client and his or her family to select services appropriate to the client's needs and the providers that will be asked to deliver the services.

(d) *Monitoring.*—After service delivery commences, the Triage team maintains ongoing contact with the client to assure that services continue to be consistent with the care plan, in terms of quality and quantity. In addition, the team consults frequently with providers and meets on a monthly basis with home health agencies in the region and other providers as needed. A medical-dental advisory committee is available to Triage staff for consultation and review of client status. The committee consists of five physicians (with different specialties) two dentists, a podiatrist and a pharmacist.

The section 222 medicare waivers have made it possible for Triage to authorize payment for many ancillary and supportive services not traditionally covered by medicare; and to waive specific medicare requirements such as coinsurance and deductibles and restrictions on home health care.

The following table describes the services available to Triage clients, including waivered services and traditional medicare services.[1]

Service category	Traditional medicare services	Waivered services
Institutional	Hospital, skilled nursing facility	Intermediate care facility, home for the aged, day care.
Home care	Visiting nurse, home health aide	Homemaker, chore, companion, meals and meal delivery.
Ambulatory	Physician, outpatient service, diagnostics (X-ray and laboratory), therapy (speech, physical, occupational). Dentist (selected medical conditions). Podiatrist (selected medical conditions).	Optometrist, dentist (routine and preventive), podiatrist (routine and preventive), mental health counselor.
Products	Medical equipment, supplies	Pharmaceuticals, hearing aids, glasses.
Transportation	Ambulance	Chair, car, taxi.

Traditional medicare services are reimbursed according to the procedures and rates of that program. For other services not normally included under medicare, the method of reimbursement varies according to service type. Homemaker and

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[1] Triage I final report, December 1979.

ICF's for example, are reimbursed on a cost reporting basis; pharmaceuticals and optical care are reimbursed using medicaid rates established by the State Department of Social Services. For other services, Triage obtained schedules from government and industry sources (e.g., Connecticut Public Utilities Commission rates used for transportation). Rates were negotiated with each provider for services such as meals and meal delivery, companions and chore service.

Triage has also provided training opportunities for providers and students in health professions programs throughout the life of the project.

Data from Triage I are currently being analyzed by NCHSR. Findings from the initial years of the project funded under the auspices of PHS, should be available in fiscal year 1981. Preliminary data from Triage I indicate that: 72 percent of participants improved or maintained their ADL (activity of daily living) and MSQ (mental status) scores. However, the overall performance of the participant group on assessment scores decreases with advancing age. The total cost per participant for 1978 was $3,620 or an average per diem cost of $12.63 per day. Data collection for Triage II is not available, as the project will not terminate until the end of fiscal year 1981.

South Carolina, Community Long-Term Care Project

The South Carolina Department of Social Services is conducting a 3-year demonstration under section 1115 of the Social Security Act to test community-based client assessment, services coordination, and provision of alternative services; and to develop proposals for permanent modification of the State medicaid program. The project has also received funds from the Appalachian Regional Commission to pay part of the administration costs of the project. A major goal of this project is to establish a community network of services that support the efforts of disabled and elderly individuals to remain in their communities. The network will have a self-sustaining community structure without a separate coordinating agency, thereby developing an integrated model for long-term care services.

Key operational components of the project include: community-based client assessment; reassessment; and service coordination toward provision of services which are alternatives to institutionalization. The population to be served are medicaid eligible elderly individuals with functional disability who are at risk of nursing home placement; 2,000 individuals are expected to participate in the project over the 3-year demonstration period, 1,000 of which will be experimentals (55 percent from the community; 45 percent from nursing homes). The control group will be randomized.

The project will provide certain waivered health-related and social services which are not otherwise covered under medicaid. These include: homemaker, chore, respite care, alternative housing, home delivered and congregate meals, and adaptive equipment in the home.

The project includes three project sites, located in three different counties. Each county site is establishing an advisory committee. The advisory committees will assist the sites in identifying service needs and priorities for new service development.

A major objective of this project is to facilitate cooperation among service providers at the community level. The existing medicaid, medicare and title XX services will be coordinated for project participants.

The assessment instrument designed to be used by the project (all sites) was based closely on the instrument developed by the Monroe County, N.Y., ACCESS project. The South Carolina instrument has undergone a number of revisions to meet the unique needs of this primarily rural project. Training has been provided to project staff in the areas of assessment, care planning and case management.

The project became operational in July 1980 in each of the three counties. Strong support has been provided by the South Carolina State Long-Term Care Council. A legislative advisory committee is providing active liaison between the project and the State legislature. In addition, the State appropriation for the project has been increased by $225,000.

The project anticipates that 1,800 medicaid eligible individuals will be referred for screening during the first full operational year.

Texas, "Modification of the Texas System of Care for the Elderly: Alternatives to the Institutionalized Aged"

The Texas Department of Human Resources (DHR), is conducting a 3-year "waiver-only" demonstration project under section 1115 of the Social Security

Act to develop and test a comprehensive continuum of care for the aged that is appropriate in terms of quality of care, preferences of recipients, and costs.

This demonstration was initiated as a result of a State legislative mandate to eliminate unnecessary and inappropriate utilization of nursing home services. The mandate requires DHR to eliminate one of the two medicaid ICF levels of care (ICF II and ICF III) and to provide community-based services to patients who can be deinstitutionalized. A State appropriation was voted to carry out the intent of the legislation.

As of February 1980 the distinction between ICF II and ICF III was eliminated so that only a single ICF program (in conformity with Federal regulations) now exists below the SNF level. Some of the individuals who were receiving benefits in ICF II are being institutionalized to community-based settings and provided with alternative health-related services. The remaining individuals will be "grandfathered" into the single ICF program.

Under this project a 5-percent sample of the 18,000 institutionalized patients in level II ICF's will be assessed to determine their discharge potential. For those who are deinstitutionalized a care plan will be developed and arrangement for in-home services through community service providers will be made. In addition, the project will conduct case management, monitoring, and followup activities for project participants.

The following services will be provided: Medicaid home care benefits, medicaid personal care benefits, title XX adult in-home services, and section 1115 waivered community based in-home supportive services.

The objectives of the project are: To create a single ICF level of care (by eliminating level II), to increase the availability of alternative care services in communities, to develop a new State assessment instrument that is appropriate for institutional discharge planning, and to assure appropriate continuing care for current level II ICF patients.

As of March 1980, the State had terminated all new admissions to level II ICF. Standards for SNF's and ICF nursing homes have been revised and new criteria for ICF's have been established. In addition, a plan for monitoring long-term care facility admissions has been developed.

The project will become fully operational in the spring of 1981.

San Francisco, Mount Zion Hospital Long-Term Care Demonstration Design and Development

The Mount Zion Hospital and Medical Center is conducting a 3-year medicare demonstration under section 222 of the Social Security Act to implement a hospital-based long-term care services delivery system in a designated service area. This model builds upon components of Mount Zion's existing geriatric services, including acute care, emergency health services, outpatient services, home care and information and referral. A consortium of five service providers under the direction of Mount Zion will cooperate to provide a range of health and social services to the frail elderly in the designated catchment area.

The project is providing centralized intake and case management, including assessment, care planning and case monitoring. It is designed to test the ability of a consortium of service providers to provide more accessible, appropriate, and cost effective care.

The project has received waivers to provide certain health-related and social services which are not otherwise provided under medicare. These include: Day care services; homemaker services; chore services; home delivered meals; interpreter services; respite care; discharge assistance; drugs and biologicals, including immunizations and those which can be self-administered; audiology services, including hearing aids; optometry services, including eyeglasses and contact lenses; podiatry services, including orthopedic footwear and other supportive devices; dental care, including prosthodontics; adaptive and assistive equipment; transportation of patients by specialty vehicles, cabs, and other private and public means; case management services; mental health counseling, including services by psychologists, psychiatric nurses, psychiatric social workers, and pastoral counselors; and prosthetic and orthotic appliances.

The basic assessment instrument used by the project is the patient status assessment instrument, which was used for the Public Health Services section 222 experiments on adult day health care and homemaker services. This instrument has been expanded to include items which are necessary for care planning and determination of appropriate patient placement. Material from the Monroe County, N.Y. (ACCESS) instrument was used in the revisions. The resulting instrument has been field-tested extensively, further revised, and validated.

The project developed a formal training program for project staff in assessment, care planning and case management functions. In addition, Mount Zion has established a seminar program to provide project staff as well as consortium members and other hospital personnel an opportunity to increase knowledge regarding long-term care. Knowledgeable individuals from the Mount Zion Medical Center and the community are leading the seminars.

In August 1980, the project became operational. The project will ultimately have a caseload of 200 experimentals and 100 controls.

Florida, Ancillary Community Care Services

The Florida Department of Health and Rehabilitative Services is conducting a 3-year "waiver only" demonstration project under section 1115 of the Social Security Act, to develop and test ancillary community care services for the chronically impaired elderly.

The purpose of the project is to establish in five Florida counties (Broward, Dade, Duval, Pinellas, and Polk) a model of preventive, maintenance and restorative health care systems for medicaid eligibles, noninstitutionalized, functionally impaired persons aged 60 and over. The project's goals include the following: (a) To assist persons 60 years of age and older identified as "at risk" of institutionalization to remain in the community by helping them maintain a level of self-sufficiency through provision of health and related services not provided under the State's medicaid program; (b) to conduct a study of individuals receiving ancillary community care services to determine the effectiveness of community based socio-medical services; (c) to evaluate the organizational structures and costs related to each site, including but not limited to: client impact, staffing, annual budgets, urban/rural orientation, service cost, referral networks, and incidence of undetected health problems.

Each of the five county agencies will be responsible for the development of individual care plans, case management, and contracting for services with local providers. The demonstration project consists of three major components:

(1) A comprehensive medical-social assessment (CMA) designed to: (a) Provide a comprehensive health examination and a functional assessment to select aged Floridians; and (b) to collect information about the general health, mental health, physical impairments, availability of social resources, unmet needs, and living conditions of older persons.

(2) A case management system; and

(3) Six ancillary community care services, including: personal care services; specialized home management services; medical therapeutic services; respite services; day treatment services; and medical transportation services.

During the first developmental year of the project, the following tasks were completed:

(1) Key staff including the project director, deputy director and data specialist have been recruited and oriented.

(2) A protocol manual for project implementation has been developed.

(3) A training program for the (five) sites has been developed, with plans to use the first site to train and orient site personnel from other sites.

(4) Contractural arrangements have been established with physicians and a management firm to help with training and administrative protocol manuals.

(5) The project has initiated working relationships with the State medicaid program.

(6) The existing State MIS has been modified to track all project expenditures, and the project has arranged with Blue Cross to perform a similar service in relation to medicare services and costs.

The project will begin in Duval County—Jacksonville, and will build incrementally on the experiences at that site to develop the other four sites. The first site is expected to be fully operational as of January 1, 1981. The project plans to recruit 50 potential participants and field test all intake and assessment procedures during the first operational month in order to refine protocols. During the first 12-month operational period, at the first site the project estimates developing a caseload of about 266 participants.

California, Multipurpose Senior Services Project (MSSP)

In September 1977 the State enacted AB998, which required the State health and welfare agency to establish MSSP across the State that would test single entry access to the health and social services system through case management, care planning and needs assessment. In October 1979, the State health and welfare agency received a "waiver-only" grant under section 1115 of the Social Security Act to implement the State mandated MSSP demonstration over a 4-year period.

The demonstration is being implemented in eight sites across the State. Some of the sites provide services directly while others are limited to case management and purchase of service functions. All sites have the authority to contract for services with local providers.

The target population for this project is persons aged 65+ who are considered at risk of institutionalization and who meet the State eligibility requirements for Medi-Cal (medicaid). There will be 1,900 participants in the MSSP; 960 will comprise the comparison group sample. The sample is being drawn from Medi-Cal eligibles from the community; acute care hospitals; and from skilled nursing facilities (SNF).

The project has medicaid received waivers to provide certain health-related and social services which are not otherwise provided under medicaid. These include: (1) Adult social care, (2) housing assistance, (3) in-home supportive services, (4) legal services, (5) nonmedical respite care, (6) nonmedical transportation, (7) meal services, (8) protective services, (9) specialized communication, and (10) preventive health care.

Other services are being provided from existing State funds under title XIX and XX of the Social Security Act and title III of the Older Americans Act, as well as the State general fund.

The demonstration has both comparative and operational objectives. The comparative objectives are: To reduce client's number of hospital days, to reduce client's number of SNF days, to reduce total expenditures of social and health services for clients, and to improve/maintain client functional abilities.

The operational objectives are: To estimate effectiveness of existing services; to estimate and compare among sites, more effective mix of LTC services; to estimate optimal expenditure for client care while reducing SNF and hospital patient days; and to estimate optimal expenditure for client care while improving or maintaining client's functional abilities.

Individual MSSP sites were required to meet specific State MSSP prescribed criteria before becoming operational. As of September 1, all eight sites were operational. (The State project became operational in March 1979.) The sites are phasing in caseloads and staffing at a MSSP prescribed pace that calls for full caseload by January 1, 1981. The eight sites are: Jewish Family Services, Los Angeles; East Los Angeles Health Task Force; Senior Care Action Network, Long Beach; Mount Zion Hospital and Medical Center, San Francisco; city of Oakland; Greater Ukiah Senior Citizens Center; County of Santa Cruz; and San Diego County Area Agency on Aging.

During the first developments, and preoperational year several major tasks were carried out. A public relations campaign was launched to inform key State and local officials and agencies about MSSP. Comprehensive planning was conducted at the site level with State MSSP involvement. Staff for the State and each site were hired, and during the months of March, June, and August all sites were trained by the State on all aspects of local MSSP operations. A comprehensive training protocol was prepared for this activity.

In addition, a patient assessment instrument was developed, pretested, and refined. This extensive comprehensive assessment instrument is conducted in two parts: social assessment and medical assessment. It is administered by a nurse practitioner and a social case worker, respectively.

MSSP has developed the data collection procedure for the participant's information, designed a system to analyze the effectiveness of the program, and designed a computerized management information system.

It is expected that all sites will have reached their full case loads, (which range from 100 to 350) by spring of 1981.

During the second year of the project, along with ongoing implementation activities, MSSP plans to initiate and implement the comparison group research activities and implement the computerized MIS system and data processing activities. In addition, it is anticipated that preliminary reports of Medi-Cal utilization trends, unit costs of services and the impact of case management hours on client outcomes will be available during the second project year.

IMPROVING NEW YORK STATE'S NURSING HOME QUALITY ASSURANCE PROGRAM

The New York State Department of Health was awarded a section 1115 waiver-only grant, effective September 2, 1980. This 3-year demonstration is part of an overall effort by the State to improve the quality of care provided in residential health care facilities (RHCF) which include both skilled nursing facilities (SNF's) and intermediate care facilities (ICF's).

DESCRIPTION

The objectives of this project are to simplify and streamline the medical review (MR) and independent professional review (IPR) and medicare review process for all RHCF's in New York State. The current system is described as very cumbersome, particularly when 8,000 reviews are processed per week. The new system will use a screening survey (based upon the screening survey developed for the Wisconsin quality of care project). It will combine a self-reported form to be filled out by the facility with a relatively brief form to be filled out by the reviewers when they visit the facility. This latter form would reduce the number of items for the SNF survey from 1,285 to 241 and the ICF requirement from 780 to 223. PMR and IPR will be combined into a single process. The first stage will be an outcome-oriented system which will look at sentinel health events (SHE's). These are defined as untoward events whose presence represents a potential failure in the care system. Examples include the presence of decubitus ulcers, urinary tract infections, and contractures. If the number of these events exceeds a threshold (to be established on the basis of the patient mix and the facility), then the second stage of the proposal will be initiated. In the second stage, a more detailed investigation of the process of care for a sample of patients having the untoward events will be undertaken using specifically designed protocols for each SHE.

The research design calls for an assessment of the extent to which the review efforts are focused on the 20 percent of facilities anticipated to be sufficiently deficient to require intensive surveys, the validity of the outcome-based screening and the process-based followup, and the relationship between deficiencies in the new process and underlying causes. Finally, various statistical measures will be applied to test the increased efficiency of the new system over the old one.

Hypotheses to be tested include:

(1) The survey emphasis on the structural measures of quality of care will complement the outcomes/process measures of the PMR/IPR to more clearly define the root causes of lack of facility compliance with State and Federal regulations. Corollaries of this hypothesis are: (a) The deficiencies noted in the new process will be directed to underlying causes rather than symptoms to a greater extent in the new system when compared with the old; (b) the plan of correction filed by the facilities will be directed to underlying causes rather than to the symptoms to a greater extent in the new system when compared to the old.

(2) Each SHE is a reliable measure.

(3) The SHE's will point to areas of poor quality care.

(4) Different reviewers will reach the same decision as to whether a stage II review is needed.

(5) Stage II review efficiently documents poor quality care when compared to the present system.

(6) Stage II reliably documents poor quality care.

(7) The new system will document more problems associated with direct patient care rather than with documentation of patient care or other indirect factors related to patient care than the current system.

The demonstration will be implemented following HCFA approval of several conditions that accompanied the grant award.

CONCLUDED PROJECTS

UNIVERSITY OF CHICAGO, NATIONAL LONG-TERM CARE PLANNING PROJECT

The University of Chicago Center for the Study of Welfare Policy, in conjunction with a consortium of universities and State and local governments received a 1-year planning grant to develop a planning framework for a coordinated approach to the design and development of long-term demonstration projects during 1979. The consortium was comprised of a core group of planners, researchers, and State and local government representatives around the country who collaborated in the design and development of demonstration projects which were to focus on developing a conceptual and operational planning framework within which alternative models of financing, organizing and delivering long-term care services can be assessed. The overall objective of this coordinated approach was to enable careful analysis of systemwide implications, to present alternative models for long-term care services, and to understand better the process through which States and localities can develop comprehensive long-term care service systems.

The universities involved in the consortium included the University of Chicago, which directed and coordinated the project through its Center for the Study of Welfare Policy in Washington, D.C.; the Center for Health Services Research at the University of Minnesota; the Health Policy Consortium, comprised of Brandeis University, Massachusetts Institute of Technology, and Boston University; and the health policy program of the University of California at San Francisco.

In addition to the development of two research demonstration projects (Illinois long-term care voucher experiment and Brandeis social HMO experiments), the consortium produced several useful analytical papers on key issues in long-term care. These papers, along with the project's final report, are available from the University of Chicago Center for Social Policy, Washington, D.C.

Wisconsin, Community Care Organization (CCO)

The Wisconsin Community Care Organization sponsored by the Wisconsin Department of Health and Social Services was awarded a research and demonstration grant under section 1115 of the Social Security Act in October 1974 and concluded its fifth and final project year in December 1979. The project submitted a five-part final report in June 1980: a State overview, the final evaluation report prepared by the Faye McBeath Institute on Aging and Adult Life of the University of Wisconsin and the three site reports. The purpose of the project was to demonstrate that a substantial segment of the elderly and disabled population can be maintained in their own homes or in community settings through the provision of a packaged continuum of health and social services.

Community care organizations (CCO's) were established in counties in three different geographical areas of the State: urban, Milwaukee; urban-rural, LaCrosse; in Barron County to provide a centralized system of coordination for all services provided to participants. The CCO's performed patient assessments, case management functions and arranged for services to medicaid eligibles through a community coordinated structure. These organizations assumed responsibility for providing health-related services to eligible patients and subcontracted with other community agencies for specific services. For a price negotiated in advance, the CCO assumed responsibility for maintaining disabled and elderly persons in their homes or in the community at an appropriate level of care. Medicated waivers granted for the project permitted reimbursement for community services that would not otherwise have been available (e.g., advocacy, adult day care, chore services, companions, counseling, home delivered meals, housing search, nutrition education and transportation).

The project had a service population of 943 clients. At two project sites impact was compared to matched control groups in other counties. At the third site, clients were compared to a control group determined by random assignment. Several different assessment instruments were administered by each site to both project and control clients to measure changes over time. The assessment instruments included: the geriatric functional rating scale (GFRS), a mechanism which measured the risk of institutionalization and also evolved as a screening device for eligibility in the program; the older Americans resources and services instrument (OARS), an extensive multidimensional needs assessment tool; the areas of care evaluation (ACE), a research-only tool used to measure client disability; and quality of life, a tool which attempted to measure client's behavior and life satisfaction.

Since the project included three sites each with distinct demographic features, variation in the organization and management structure and different approaches to client assessment, the final evaluation report analyzes experimental and organizational project findings by site.

In the organizational analysis, the evaluators focused on planning, development and implementation of the CCO project from its inception through establishment of the sites.

Overall, the data from the project findings show that for CCO clients there was a significant reduction in acute hospital days and SNF days, when compared to the control and comparison groups. At the LaCrosse and Milwaukee sites the experimental patients had lower death rates than the control groups.

Major organizational findings included: A consistent theme of turf defense and domain protection among providers who saw CCO as potentially threatening to their vested interests. The complexity of service delivery relationships among agencies was underestimated, resulting in less than optimal strategic decision-making. CCO was able to change service system behavior in LaCrosse and Milwaukee, but only minimally.

Following are highlights from each of the sites:

CCO Milwaukee

Randomly assigned experimental and control groups did not seem to differ in important ways.

Experimental group members had, on the average, more difficulty with activities of daily living, were at less risk of institutionalization and were more disabled than the total CCO Milwaukee client population.

Almost half of the experimental clients received no more than two services funded by CCO Milwaukee.

Transportation, nutrition, home maintenance and personal care were the most frequently utilized services.

Medical assistance cost analysis indicated that, for the normal medicaid program, experimentals cost $197.87 per client per month while controls cost $325.42.

CCO Milwaukee experimentals showed savings in outpatient medical services, hospital costs, nursing home costs, costs for home health care and drug costs.

Total medical assistance costs, including CCO costs, were determined to be $330.04 for CCO clients, or $4.62 per client per month more than the regular program without CCO. Taking the assigned Milwaukee clients out of this analysis, the costs rose to $362.64. CCO costs are slightly over-estimated owing to the inclusion of research costs.

CCO Milwaukee did not appear to have an effect on the rate of institutionalization in nursing homes. However, CCO Milwaukee had fewer total days in nursing homes and fewer total hospital days than controls.

Quality of life deteriorated in both experimental groups, suggesting no experimental effect.

CCO LaCrosse

Clients living with relatives had higher service costs than those living alone.

196 clients were "case management only" clients. On the average, these clients were older than other clients, in slightly greater risk of institutionalization than medium cost clients and about the same level of disability as high cost clients.

The mean monthly medical assistance cost for LaCrosse clients was $189.45 as compared with $150.19 for Eau Claire controls.

LaCrosse clients experienced fewer hospital days and fewer nursing home days than Eau Claire controls, but higher medical assistance costs.

LaCrosse clients showed increasing risk of institutionalization over time while Eau Claire controls showed less risk.

LaCrosse clients showed less institutionalization and lower death rate than Eau Claire controls when matched on disability and risk levels.

LaCrosse County showed substantial increases in institutional utilization when compared with Eau Claire County. Only a minor change was noted in the number of licensed beds.

In terms of quality of life, LaCrosse clients showed only three positive comparisons and 17 negative ones over time. This was compared with Eau Claire's eight improvement comparisons with no regression.

CCO Barron

The mean monthly cost to the medical assistance program for Barron clients was $164.41, including evaluation costs.

Barron's clients showed gains in GFRS and areas of care evaluation (ACE) functioning at 6 months, but these gains seemed to disappear over time.

148 clients were active at the conclusion of the data collection period, compared with 22 who had died and 18 who had been institutionalized.

Barron County experienced decreasing institutionalization when compare with Clark County.

Barron's aged were significantly more expensive to provide service for tha were the disabled.

There were no significant differences among the service costs for Barron developmentally disabled, mentally ill and physically disabled.

Married client service costs were about the same as for single individuals; there were no differences between those living alone and those living with others.

Recently, in an effort to phase out the project's waivered services and the CCO activities, the State wrote into the 1980 medical assistance administrative rule that eligible CCO clients who were receiving benefits or services from the local project sites as of April 1976, would be allowed to continue to receive these CCO services. The three CCO sites have been certified as providers under the medical assistance plan. Under the plan, the sites are able to provide both the regular medicaid services and the services formerly provided under waiver. The nonmedicaid services are now paid out of a State appropriation. Following is the current status of the three sites:

—The Milwaukee site had enrolled 768 clients as of December 31, 1979 and will continue to serve those "grandfathered" clients.

—In Barron County a limited staff will remain to continue providing services to clients who had been served under the demonstration.

—In LaCrosse County, a newly created aging unit will continue to serve the current CCO client population, and continue the system of services and case management.

SPECIAL INITIATIVES

NATIONAL LONG-TERM CARE DEMONSTRATION PROGRAM

In fiscal year 1980, Congress appropriated $20 million to support the national long-term care demonstration program. This intradepartmental effort was launched in an attempt to test the ability of community-based long-term care projects to address many of the inefficiencies in the existing long-term care system and assess the factors which influence their structure. $10.5 million was appropriated to HCFA and $10 million was appropriated to the Administration on Aging (AoA) for this initiative.

The program is an intradepartmental effort which includes the close cooperation of HCFA, AoA, the Public Health Service, and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) which was designated the lead agency in the effort. A steering committee of senior policy officials in these agencies has been established under the chairmanship of ASPE to set broad goals and provide policy guidance regarding the program. An intraagency management team has also been established, composed of senior staff in each participating agency, which has responsibility for providing technical direction and management on all aspects of the program.

On September 30, 1980, the Department announced implementation of the program, which includes the following four components:

1. Channeling Demonstrations

Twelve States were awarded contracts to conduct channeling demonstrations. The term "channeling" refers to the organizational structures and operating systems required in a community to make sure a client receives needed long-term services. The primary elements of this concept are: (1) case finding, (2) comprehensive client assessment, (3) case management, and (4) monitoring and reassessment.

Of the 12 channeling demonstrations, 6 are being monitored by HCFA (Maryland, Maine, Pennsylvania, Kentucky, Texas and Hawaii) and 6 are being monitored by the Administration on Aging (Florida, Massachusetts, Missouri, New Jersey, New York and Ohio).

2. Evaluation Contract

Each project will collect data in a uniform manner for use in the Department's national evaluation of the program. The evaluation will collect uniform data on client characteristics, outcomes and costs. The evaluation contractor is Mathematica, Inc.

3. Technical Assistance Contract

A Technical Assistance contract has been let to provide support to the 12 demonstration projects in developing uniform assessment and data collection procedures. The technical assistance contractor is Temple University Institute of Gerontology.

4. State System Development Grants

Fifteen States have received 1-year system development grants. This grant program, which is intended to help States build their capacity to plan, coordinate and manage the allocation of long-term care resources, will terminate at the end of fiscal year 1981. The system development program parallels task I of the State long-term care channeling demonstration contracts.

The system development grants are being monitored by AoA. The evaluation and technical assistance contracts will be jointly monitored by teams comprised of representatives from ASPE, HCFA and AoA.

A portion of funds from this initiative will also be used to gather baseline data necessary to evaluate the sites and to derive national estimates from the demonstration experience. In this regard the following new surveys and modifications of existing surveys is planned:

(1) A new inventory of community long-term care (LTC) providers to obtain information on the supply of these providers and to provide a sampling frame for a study of the clients of such providers.

(2) A new household panel survey which will provide information on a nationally representative sample of impaired individuals internally linking data on degree of impairment, services received, cost of care, informal supports received, household income, etc. It is recommended this survey be piggybacked on the Department's survey of income and program participation (SIPP) in 1984 with supplementation of the SIPP sample of severely impaired individuals.

(3) A new survey of individuals in LTC institutions which together with the household survey will provide a complete picture of the population in need of LTC. The recommended option for this study would cover a broadened definition of LTC institution (e.g. institutions serving the mentally ill would be included) and would reinterview clients over the course of a year to gain more accurate data on charges and financing and information on change in client status unavailable from past cross-sectional nursing home surveys.

(4) A study of State government programs to provide information by program on expenditures, reimbursement practices, management techniques, etc. Major programs include medicaid, title XX, and title III of the Older Americans Act, but information will also be obtained on other Federal programs and on State programs.

(5) An analysis of exisitng data sets containing policy relevant information bearing on LTC policy questions and implementing the recommendations of the Interagency Statistical Committee on Long-Term Care for the Elderly and analysis of data of the new surveys.

HUD/HHS DEMONSTRATION PROGRAM FOR DEINSTITUTIONALIZATION OF THE CHRONICALLY MENTALLY ILL

The Departments of Housing and Urban Development (HUD) and HHS are jointly funding this demonstration with the goals of: (1) Integrating the chronically mentally ill into the community and improving the quality of their lives by providing housing arrangements linked to supportive and rehabilitative services; (2) providing an environment that protects the privacy and personal dignity of the chronically mentally ill and at the same time offers incentives and encouragement for them in assuming increasing responsibility and control over their own lives; and (3) encouraging and assisting States in providing housing and comprehensive health/social services for the chronically mentally ill.

The demonstration is one part of the initial response of the two agencies to the recommendations of the General Accounting Office and the President's Commission on Mental Health that relate to deinstitutionalization, housing, and service provision for the chronically mentally ill. For this demonstration, the chronically mentally ill are defined as "any adult, age 18 or older, with a severe and persistent mental or emotional disorder that seriously limits his or her functional capacities relative to primary aspects of daily living such as personal relations, living arrangements, work, recreation, etc., and whose disability could be improved by more suitable housing conditions." (Alcoholism and drug abuse are not included in this definition.)

The following three categories of individuals may be served:

—Chronically mentally ill individuals currently residing in institutions but capable of more independent living;

—Chronically mentally ill individuals at risk of being reinstitutionalized;

—Chronically mentally ill individuals with no prior institutionalization who are at risk, but for whom housing linked to services would provide an alternative to institutionalization.

Under this demonstration, provision of the following services is required: Case management and program planning, house and milieu management, life skill development, medical and physical health care, and crisis stabilization.

Additional services that are recommended but not required: Vocational development, education development, family relations planning, recreational/avocational activity planning, psychotherapy, and advocacy/legal assistance.

Under the authority of section 202 of the Housing Act of 1959, as amended by Public Law 86-372, HUD is providing 40-year direct Federal loans to assist private, nonprofit corporations in the development of new or substantially rehabilitated housing. Over a 3-year period, HUD has set aside approximately $69 million in loan reservations for 229 sites in 39 States, including the District of Columbia and Puerto Rico. These sites will house from 3,500 to 4,000 residents. In addition, HUD will provide section 8 rental assistance for 100 percent of the units constructed or rehabilitated.

This community based residential housing (group homes and independent living complexes) will allow chronically mentally ill persons to live more independently in the community. A group home is defined as a small living arrangement for not more than 12 persons with a home-like environment for those who require a planned program of continual supportive services and/or supervision, but do not require continual nursing, medical or pyschiatric care. An independent living complex is defined as an arrangement of six to 10 individual apartment units that are supervised by professional or paraprofessional staff living in a separate or adjacent apartment or living off the grounds of the facility. The complex may house no more than 20 individuals with a maximum of two persons per bedroom.

Through a cooperative arrangement with HUD, HHS (HCFA, NIMH, and ASPE) will assure that the residents of the demonstration will receive an appropriate service package and reimbursement for selected services. A steering committee comprised of staff from each agency provides review and input into each phase of the program. ASPE has had the HHS coordination role, NIMH provides the guidance, direction, and review of the service component, and HCFA is committed to the approval of section 1115 waivers to provide medicaid reimbursement for services that the States are unable to pay for under current funding programs. This reimbursement mechanism is considered to be transitional in that it allows a State time to secure funding for these services and thus fulfill its commitment to HUD. Each site within a State is to be covered by waivers to be approved for 3 years.

Up to 26 States are expected to submit section 1115 waiver-only grant applications to HCFA. In addition to waiving specific sections of the statutory requirements for the medicaid State plan, the grant will authorize Federal matching funds for such services as case management, supervision, training in life skills and transportation. The Minnesota Department of Public Welfare now has an approved grant and has one site providing services. Georgia, Vermont, Oregon, and New Jersey have also submitted applications and expect to have sites ready to provide services early in 1981.

HHS will conduct a 4-year cost-benefit evaluation of the demonstration with HCFA as the lead agency in this endeavor. Funding for the evaluation has been committed by NIMH and ASPE. It is expected that the evaluation design, developed under contract with Urban Systems Research and Engineering, Inc., will be pilot tested in 1981. The schedule of events relating to the evaluation will be determined by the date on which a sufficient number of sites become operational.

Research Activities

ON-GOING PROJECTS

Dallas, Tex., University of Texas Health Science Center—Public Programs' Impact on Long-Term Care Facility Utilization by the Elderly

The major objective of this project is the exploration of the relationship between nursing home utilization and the levels of social services and income maintenance programs available outside the institution. The project specifically will attempt to determine whether or not the amount of public income maintenance and social service support available to residents of the community is related to extent of nursing home utilization.

There are three primary objectives of the proposed research:

(1) To identify the critical socioeconomic and demographic determinants of substitutability between alternative long-term care (LTC) settings.

(2) To investigate the magnitude of social service expenditures and income support programs on nursing home and personal care utilization, with emphasis on rates at which existing capacity is utilized, rates of utilization of the aged segment of the population, and the duration of illness.

(3) To predict future capacity requirements based on plausible public expenditure levels.

The research design proposed involves analyzing the determinants of three different measures of long-term care utilization (mean LTC duration of stay, mean LTC occupancy rates, and number of residents per thousand of aged population) for two alternative institutional arrangements (nursing home care and personal care with or without nursing). The project will use a log-linear model specification to investigate the impacts on these LTC measures of various socioeconomic and demographic variables (e.g., poverty, educational attainment, health status, prices of home nursing care and for general LTC services), social service and income maintenance variables (e.g., social security benefits, medicare and medicaid home health care expenditures, average medicaid payment rate, and other social service expenditures targeted primarily for the elderly), and the long-run adjustment to the optimum stock of LTC beds.

The final report from this project is due early in 1981.

New York City, Community Research Applications—Information About and Attitudes Toward the Use of Long-Term Care and Community-Based Alternatives Among Blacks, Hispanics, and Whites

This 1-year project, which began in September 1979 will examine consumer information about, and attitudes toward, the use of long-term care and community-based alternatives, particularly those alternatives which may act so as to prevent or postpone long-term institutional placement in intermediate care or skilled nursing facilities.

The objectives of this project are as follows:

(1) To identify the extent of minority information about long-term care and about community-based alternatives in communities in which actual availability and characteristics of services are known and have been quantified.

(2) To identify what service characteristics, e.g., service location in a minority neighborhood, minority staffing, minority-white client ratio, affect minority willingness to use long-term care and alternate services.

(3) To identify the personal characteristics and functional limitations which affect minority willingness to use long-term care alternative services.

(4) To examine the decisionmaking process as regards the selection and use of different health care modalities.

The final report for this project is due in December 1980.

University of Michigan—Forecasting Geriatric Home Health Outcomes from Personal, Familial, and Systemic Variables

In this 1-year project, which began in November 1980, a multivariate analyses will be conducted to identify the effects of referral source and service utilization on the outcomes of geratrics home care. The source of the data are cases served by the San Francisco Home Health Service Agency from 1957 to 1975.

By expansion and/or refinement of variables and confidence intervals, the project will attempt to establish multiple indices of causality. The findings will facilitate the refinement of criteria for decisionmaking for geriatric long-term care. The analysis will examine the relationships of service input to the outcome of the patient at discharge or after a period of care, and the relationship of the variables at entry to utilization patterns and outcome status. Variance in care outcome will be related to numerous personal variables, familial/residential variables and contextual or institutional variables.

The final report for this project is due in early 1981.

Washington, D.C., American Association of Homes for the Aged—Factors Influencing the Provision of Noninstitutional Long-Term Care by Homes for the Aging: A Study of Long Term Care Center Feasibility

This project will analyze data on outreach services from members of the American Association of Homes for the Aged. Among the issues to be explored are:

—The type, frequency, and level of noninstitutional care services provided by homes.
—Type and mix of funding sources used to finance outreach services.
—Groups of services provided (those services most frequently provided in association with other services).
—Characteristics of homes with the largest and most extensive outreach programs, as well as those with few or no programs.
—Percentage of minorities served as residents in the home versus recipients of outreach services.
—Expansion rate of homes providing outreach services.
—Participating or nonparticipating medicare/medicaid homes which most typically provide outreach services.
—Outreach activities of homes drawing large numbers of residents from outside their health services area (HSA).
—Characteristics of homes providing senior center activities in the homes for nonresidents (inreach versus outreach).
—Activity of congregate care (life care) homes in the provision of outreach services.
—Characteristics of homes which provide more medical care versus those providing nutritional or social services.
—Level of outreach provided through charitable contributions.
—Level and area of administrator education compared to level of outreach program activities.
—Sponsorship of homes (public, religious, fraternal) and level of outreach activity.

Approximately 200 of the homes, with various levels of outreach programs, will be included in another survey to be supported by this grant. In-depth data will be gathered on (1) community characteristics of the homes, (2) recipient characteristics, (3) outreach program description, and (4) funding characteristics.

Final results from this 1-year project will be available in mid-1981.

Duke University—Bioactuarial Estimates and Forecasts of Health Care Needs and Disability

The objective of this project which began in June 1980, is to study the health status of the U.S. population using a model of the natural history of important chronic diseases for the individual, adjusted for the effects of population dynamics. This model, which integrates evidence from several sources (vital statistics, epidemiological studies, clinical findings, and physiological models), will be used to produce distributions of chronic diseases (differentiated by stage of disease and associated conditions) in the U.S. population, stratified by age, race, sex and geographic area.

A major rationale for the study is the derivation of more accurate estimates of the prevalence and incidence of chronic diseases so that better estimates of health care costs can be derived. Current estimates of medical needs are inextricably confounded with demand (which is strongly related to the level and availability of health care services). Adequate information presently seems to exist on the unit cost of medical services and various economic theories have been promulgated for the health care sector of the national economy. However, before this information and theory can be successfully applied to projecting, monitoring and controlling health care expenditures, it is necessary to produce better and more detailed estimates of the level of medical need. Such improved estimates could then be used as inputs to the efforts at economic forecasting.

The methodology for deriving national population-specific estimates of chronic health problems centers on new analytic strategies (e.g., stochastic process modelling) which permit one to infer chronic disease incidence and prevalence patterns from national cause-specific mortality data. The morbidity and disability distributions are inferred from the morality data by extrapolation from age and cause of death, backwards through the "health history" of the individual as implied from biomedical and epidemiological evidence about the behavior of chronic diseases. Once the "health histories" for individuals are assembled into the morbidity distributions for the population it will be possible to generate measures of health care need and long-term disability. The estimates of chronic disease incidence and prevalence generated by the proposed methods will be much less subject to confounding with the psychological and market factors determining health care demand than are estimates of health needs available from other sources. Data for these analyses are from various sources, but primarily the national vital statistics files. Such vital statistics represent near total coverage of all deaths in the United States (hence, they are divorced from selection for health providers, are gathered continuously over time, are large in number, contain a listing of specific medical conditions at death, and represent a specific and crucial point in the natural history of chronic disease processes.

This project is expected to conclude in mid-1981.

University of Washington—Cost Containment by Nursing Home Administrators

The primary objective of this project is to analyze the impact of cost containment efforts by nursing home administrators on the cost of services and quality of care in long-term care facilities.

This project will research in detail the variety and efficacy of cost control (containment) methods currently being utilized by nursing home administrators to aid in the improvement of methods for administratively controlling costs.

A second objective of this project is to study the impact of contextual variables (specifically: facility size and external pressures) on administrators' programs to contain costs.

This project will utilize a pretest-posttest control group design. Half of the randomly selected homes will be assigned to the control group; half to the experimental group. Data will be gathered by interviewing personnel within each facility (including the nursing home administrator, nursing director, dietary supervisor, two registered nurses or licensed practical nurses, two nurse's aides and two dietary aides), and from on-site visitations. Baseline information will be gathered on (1) the presence and use of cost control methods, (e.g., budgets, cash flow reports, revenue and expense statements, employee turnover reports, comparative cost models, and so forth), (2) the efficiency (cost of services) and effectiveness (quality of care) of nursing home performance, and (3) the presence and intensity of external contextual pressures on nursing home administrators.

Afterwards, the nursing home administrators in the experimental group will receive training in the variety of methods and efficacy of implementing cost controls. Then both experimental and control groups will be retested.

This 2-year project will conclude late in 1981.

New York City, Hunter College and the Research Foundation of City University of New York—The Role of Families in Providing Long-Term Care to the Frail and Chronically Ill Elderly in the Community

The overall goal of this study is to examine the family care-giving systems of the frail elderly. Two hundred persons will be selected for the sample and will be from three major ethnic groups: white, black and Hispanic. They will be family members of older persons who have requested and/or received services from the social and health care system in New York City and will be interviewed to provide data relevant to the study objectives listed below:

(1) Examine family care-giving systems of frail elderly.

(2) Document types of services and extent of commitment.

(3) Assess economic value of services.

(4) Determine impact of care on family unit in both psychological and financial terms.

(5) Determine knowledge, utilization and satisfaction with publicly financed social and health care service.

(6) Identify factors that strengthen or weaken family homes in providing care to an elderly relative.

(7) Estimate costs and benefits of current hypothetical home care plans, which include family support services.

(8) Recommend methods of enhancing the family care-giving system which would result in the most efficient use of public service dollars.

The findings from the study will result in:

(1) A descriptive picture of the characteristics of family care-givers, the tasks they perform, and the social and economic impacts they experience in doing so.

(2) Identification of the medical and social characteristics of the patient/care-giver dyad which predict the extent to which supportive home care services will be needed.

(3) Recommendations regarding the types, quantity, and providers of home care necessary to sustain the elderly in the community and to avoid more costly alternatives.

The final report from this project is due late in 1981.

University of Colorado—Long-Term Care Reimbursement and Regulations

The University of Colorado, under this grant, which began in March 1979, is studying the empirical interrelationships of patient mix (case mix), quality of care and costs in nursing homes in Colorado, and assessing the practical implications of the findings for reimbursement and regulation policies. This project is in the second of a 3-year study to explore ways to improve the long-term care system so that quality of life of populations served can be improved at a reasonable cost to both government and private parties. The products of this study will be useful in assisting public programs to develop procedures designed to measure patients' need for services, to monitor that quality of care provided so that these needs are met, and to insure that the cost is commensurate with the level of care provided.

The objectives for the second year study remain unchanged from those originally proposed:

(1) To analyze case mix, quality and cost at the facility level.

(2) To analyze case mix and quality at the resident level, and to design an approach for analyzing cost at the resident level.

(3) To build a data base for longitudinal analysis at the facility level by collecting data for 1979 and 1980.

(4) To analyze reimbursement and regulatory systems and to assess the implications of study results for such systems.

(5) To refine methodology for sampling residents within nursing homes to obtain accurate assessments of both case mix and quality.

The project will conclude early in 1982.

Boston, Mass., Peter Bent Brigham Hospital—Innovative Methods of Pricing Ambulatory Care Treatment for Patients With Hypertension

The overall goals of this project are to devise for the medicare and medicaid program reimbursement techniques that encourage the most economical, efficient, and effective long-term management of hypertension. By reducing excess mortality and morbidity from cardiovascular disease, these measures should improve health outcomes for participants, and reduce health care costs.

In order to develop these techniques, this project proposes to study the experience of the 14 clinical centers throughout the United States that participated in the recently completed 5-year hypertension detection and followup program (HDFP) of the National Heart and Lung Institutes.

The hypertension detection and followup program (HDFP) is one of the largest randomized controlled trials ever undertaken. This program was instituted by the National Heart, Lung, and Blood Institute of the National Institutes of Health in 1971. The primary goal of the program was to determine whether systematic antihypertensive therapy, compared to customary medical care, can effectively reduce morbidity and mortality in a wide spectrum of persons aged 30 to 69 years who had an elevated blood pressure.

The initial goals for this project include:

(1) To ascertain how much care, on the average, was rendered for the treatment of hypertension under the HDFP protocols for stepped care established in the participating 14 clinical centers.

(2) To investigate how this average quantity of care varied with the characteristics of patients, the stages of their disease, and the differences among the 14 clinical centers in the manner in which care was provided.

(3) To review the findings with the directors and staff of the clinical centers in order to segregate that portion of the care that would be considered essential for the optimal treatment of different types of patients at different stages of the disease from that portion of the care that was in fact rendered to implement the research component of the HDFP program.

(4) With the aid of the findings from the Delphi interview methods to be applied in (3) above, to construct profiles of the estimated care required for the effective treatment of hypertension, stratified by age, race, sex, and stage of the disease.

(5) To estimate the cost of providing such services under the medicare and medicaid programs under various assumptions concerning the prevalence of hypertension and the reimbursement mechanisms that might be used.

The long-term goals, which are to be approached from the foregoing background are:

(1) To propose innovative methods of pricing ambulatory care treatment (IMPACT) for hypertension that will encourage the efficient and economical provision of effective care under the medicare and medicaid programs.

(2) To plan an appropriate demonstration project in which price schedules developed under the IMPACT program would be tested.

Final results from this project are due in mid-1982.

University of Minnesota—Collection and Dissemination of Data on Long-Term Care Residential Facilities for Physically Disabled Individuals

The purpose of this project is to collect and disseminate data and disseminate data on U.S. long-term residential institutions for physically disabled individuals.

This project has several specific objectives:

(1) To gather information on the characteristics of U.S. long-term care public residential facilities for physically disabled individuals (e.g., geographic location, number, size, expenditures, rates of admission, sponsorship, etc.).

(2) To gather information on the demographic characteristics of persons who reside in these facilities.

(3) To gather information on the nature and characteristics of services provided to physically handicapped individuals, both within and outside of residential facilities.

(4) To write a report on the policy implications of the data collected for the use of (a) policymakers and planners at local, State, regional, and national government levels, and (b) for consumers of such services.

(5) To gather information which is necessary for effective planning, improvement, and evaluation of long-term care public residential facilities, and the services they provide.

(6) To evaluate the progress being made by various levels of governmental agencies in the implementation of national goals concerning the integration of physically handicapped people into the "mainstream" of communities, including cost and financial data.

(7) To collect nationwide information on the licensing practices of states, the development of instruments, and methods of data collection (including the development of a registry of all long-term care residential facilities primarily serving physically handicapped individuals). Efforts will result in a prototype information system useful for the design, planning, and organization of services for physically handicapped individuals.

The expected completion date for this project is mid-1982.

Washington, D.C., The Urban Institute—Implications of Medicare and Medicaid Policies for the Nursing Home Market

The Urban Institute was awarded a 3-year grant to study the impact on the nursing home market of selected medicare and medicaid policies. The study will be a comprehensive analysis of the effects of medicaid reimbursement policies on nursing home cost inflation. The study will also assess the impact of reimbursement policies on the quality of care, access and changes in industry characteristics.

The importance of the study results from the major role of medicaid in financing nursing home care and the rapid rate of increase in nursing home costs. Nursing home costs per day rose faster than hospital costs per day between 1967 and 1977.

Data from cost reports of 250–300 nursing homes in each of 4 years (1977–80) in eight States will be analyzed. States will be selected for both their importance in terms of the size of the industry and for their thoughtful approach to reimbursement policy. The inflation analysis will examine various cost components, as well as total costs. Disaggregation by types of homes will examine the behavior of different ownership types, of high and low cost homes, and of homes with high and low proportions of medicaid patients.

A second part of this project will consist of an investigation of factors affecting participation in medicare by skilled nursing facilities. The role medicare policies and the interaction of medicare and medicaid policies will be examined. The analyses will be based on both case studies and quantitative models.

The final report will be due in 1983.

New York City, Community Service Society—Impact of Home Services for Functionally Disabled Adults

In this project, which began in June 1980, functionally disabled low-income adults will be followed for 12 months after acute hospitalization to determine the impact of substantial, ongoing home service programs which are largely medicaid-financed.

The purpose of the research is to test four major hypotheses.

(1) Among functionally disabled adults of modest financial means, those eligible for publicly financed home services will tend to make greater use of home services and, in turn, experience better solutions to problems of daily living.

(2) Greater availability of publicly funded home services will lead to diminished use of inpatient hospital services and long-term care institutions.

(3) Use of organized home services is greatest among those with the weakest family resources. Where family resources are present, introduction of home services will reduce, but not eliminate, family participation in care. Home services will tend to diminish the burden experienced by family members who participate in long term care.

(4) At various levels of functional disability, persons living independently who receive publicly funded home services will tend to experience solutions to problems of daily living which compare favorably to those experienced by institutionalized persons.

In addition to these hypotheses, the applicant intends to address other questions which are listed under seven substantive areas. These areas are: (1) accessibility of home services; (2) service delivery questions; (3) personal survival and durability of care arrangements; (4) rehabilitation; (5) cost containment; (6) quality of circumstances of the functionally disabled; and (7) family contributions to care.

The completion date for this project is mid-1983.

University of California, San Francisco—Long-Term Care: Impact of State Discretionary Policies

This 3-year research project, which was initiated in March 1980, will study (1) currently available State data on long-term care (LTC), and (2) State discretion in the major programs affecting availability, scope, and cost of long-term care services for the aged.

This project has seven objectives:

(1) To assess existing data reporting systems with respect to their content and comparability, including expenditure and utilization data, for long-term care services for the aged.

(2) To provide an inventory of current State policies affecting long-term care for the aged in three major programs: Title XVI (supplemental security income), title XIX (medicaid), and title XX (social services) of the Social Security Act.

(3) To assess the relation of preconditioning variables (e.g., perceived fiscal crisis in the State and policy responses, economic conditions, etc.) to State discretionary long-term care policies and outcomes (e.g., expenditures, utilization).

(4) To assess how State discretionary policy choices affect the availability and utilization of long-term care services for the aged.

(5) To assess how State discretionary policy choices affect the total cost and distribution of Federal, State, and local expenditures for long-term care services for the aged.

(6) To assess how State discretionary policy choices affect payment systems for LTC, especially in the private sector, and to assess the effects of these systems on the utilization of and expenditures for LTC services for the elderly; and

(7) To assess the implications for Federal and State policy, particularly with respect to effectiveness of cost containment strategies, and to examine alternative Federal and State policies based on these analyses.

This project will conclude in mid-1983.

University of Colorado—Comparison of the Cost and Quality of Home Health and Nursing Home Care

The center for Health Services Research at the University of Colorado Health Sciences Center was awarded a grant to evaluate nursing home and home health care provided in both free-standing and hospital-based settings.

The purpose of the project is to assess both the cost and quality of care provided under four organizational arrangements: free-standing nursing homes, hospital-based nursing homes, free-standing home health agencies, and hospital-based home health agencies. Policy issues addressed will include the following: Do the higher costs of hospital-based facilities justify different treatment from free-standing units for reimbursement and regulatory purposes? Is home health care a cost effective substitute for nursing home care for certain types of patients?

The study will utilize a stratified sample of 16 providers from each modality. Two samples of patients will be drawn from each provider, one random and one stratified in terms of case mix. Forty patients from each provider will be selected for a total of 2,560 patients.

The project will first compare the case mix of patients served by the four modalities using the random samples of patients. Second, costs, quality and cost effectiveness of the four modalities will be analyzed using the stratified patient samples to control for case mix and other factors.

The study will be conducted over a 4-year period, and final results will be available in 1984.

New York City—Delivery of Medical and Social Services to the Homebound Elderly

The New York City Department for the Aging is conducting a 3-year medicare demonstration of the delivery of medical and social services to the homebound elderly, under section 222 of the Social Security Act. A separate grant from the Administration on Aging is supporting certain administrative activities and supplemental service delivery costs for the project.

The purpose of the demonstration is to test a community-based methodology which will provide a spectrum of medical and social services, directly and by linkage and coordination, to a home-bound chronically ill population. Specifically, the project is targeted to persons aged 65 and over entitled to medicare part B who suffer from chronic illness, functional or mental impairment and who are unable to visit a physician without assistance or have no access to medical care.

Four sites will be developed, each serving 100 individuals (totaling 400 participants for the project) with a comparison group of 200 for research purposes. The project's major objectives are threefold:

(1) Identify characteristics of this population, needed levels of care, cost of delivering such care, and the effect of care delivery.

(2) Demonstrate the process of coordination, and identify mechanisms and strategies effective in achieving coordination; and

(3) Develop a cost-effective model of coordinated service delivery to be incorporated into the city's system.

A coordinating model has been established to carry out the project, composed of separate organizational components, each with specific responsibilities related to coordination and service delivery. These components include a project advisory committee which is comprised of relevant city departments and four neighborhood-based service delivery sites. The project advisory committee reviews policy, selects sites, and establishes criteria for clients and services. The committee is also responsible for facilitating agreements between service providers. The neighborhood based sites will conduct centralized intake, assessment, care planning, reassessment and monitoring, conducted by an interdisciplinary team (e.g., nurse and social worker).

Each site will have a physician consultant whose responsibilities will include:

(1) Participation in selected care planning conferences.

(2) Serving as a consultant to the nurse and social worker on medical management problems of clients.

(3) Making specialized assessment visits to clients who have no physician in the community, signing off on the care plans developed by the case management team for such clients (wherever a client has a personal physician, he or she will approve the client's care plan); and

(4) On behalf of the assessment team, intervening in client situations where current medical care is no longer adequate.

The project is developing the four sites incrementally; two became operational in December 1980, and two more will be operational by March 1981. The first two sites are: Sunset Park Family Health Center (Brooklyn) which is part of Lutheran Medical Center (but functions as a freestanding clinic). Community Agency for Senior Citizens, which is sponsored by the Staten Island Home Care Integration Service Coalition and funded under Older Americans Act, title III-B.

The next two sites are: Jamaica Service Program for Older Adults (Queens) which is a voluntary social service agency providing a broad range of services to the elderly in this borough, including services funded under title III-B of the Older Americans Act. The Comprehensive Family Care Center (Bronx) which is sponsored by the Albert Einstein College of Medicine.

The four sites may provide services directly, contract for, or arrange for other services in their respective catchment areas.

Services to be provided through the medicare waivers are the core around which other community services will be obtained for project clients. These services are: Homemaker, personal care services, transportation and escort services, and drugs and biologicals.

The assessment instrument is based for the most part on the Georgia Alternative Health Services "client assessment interview," together with the New York State DMS-1 medicaid preadmission instrument.

REIMBURSEMENT

THE FLEXIBLE LEVELS OF CARE EXPERIMENT

The Connecticut Department of Income Maintenance was awarded a 1-year planning grant for a 3-year demonstration on September 30, 1979. The State plans to demonstrate an innovative approach to levels of nursing home care: a separate level of skilled nursing patients, a level of "total care" patients, and a number dually licensed/certified beds; to coordinate these new levels of care with the reimbursement system; and to develop profiles for patients who will be classified and reimbursed as total care patients.

The proposal includes two components: a service or administrative phase and an evaluation or research phase.

A. Administrative or Service Phase

(1) A project director, planning analyst, and secretary will be assigned to the Department on aging.

(2) Twenty-two chronic and convalescent nursing homes will volunteer to participate in the project. One-half will be randomly assigned to the experimental group and one-half to the control group.

(3) In experimental homes (an average of 102 patients in nursing homes in Connecticut), 30 beds will be set aside as the skilled/swing unit and the remaining beds (70-75 beds) reserved for total care patients. Total care patients make up 80-85 percent of the patients in chronic and convalescent nursing homes (CCNH) in Connecticut. Connecticut PSRO's estimate that fewer than 10 percent of patients in Connecticut's CCNH meet the Federal definition of skilled care, yet all CCNH patients are being reimbursed at the skilled level.

(4) Patients will be assigned to levels of care in the 11 experimental homes as determined by PSRO reviews.

(5) Patients designated by PSRO as rest home with nursing supervision level of care will be transferred to those facilities.

(6) Nurse staffing in the skilled/swing units and total care units in the experimental CCNH will be increased from the present minimum State staffing requirement to provide a higher level of care. Costs of additional staffing will be paid from grant funds.

(7) It is planned that there will be linkages with other State based projects; i.e., Triage, sail, find, adult day care, and others, although the method of linkage was not clarified.

(8) Five 1115 waivers have been requested; Statewideness, levels of care, differential in rates, differential in staffing, and dually licensed beds.

B. Evaluation or Research Phase

(1) A part-time project director, research analyst, systems analyst, key punch operator, secretary and four data collectors will gather data, analyze the findings, share results with central administrative staff, and make recommendations for State and nationwide applications.

(2) The evaluation team will evaluate the process and systemic effects of the demonstration, gather client profiles, and determine outcomes and costs of flexible levels of care. A number of hypotheses have been stated.

(3) It is planned that the demonstration will be evaluated by an outside agency; therefore, hypotheses, data collection instruments, method of analysis, reports, etc. have not been spelled out in detail.

Work accomplished to date include:

(A) Memorandum of agreement between departments of income maintenance and aging.

(B) Employment of qualified principal investigator and support staff.

(C) Selection of sample nursing homes and development of a letter requesting participation in demonstration.

(D) Work initiated with PSRO's to coordinate demonstration with PSRO survey of nursing homes involved.

(E) Meeting with community leaders and representatives of proprietary and nonprofit homes to describe the study and solicit cooperation.

(F) Continuation proposal to be submitted before October 6 for November review.

WAIVER OF PRIOR HOSPITALIZATION REQUIREMENTS FOR MEDICARE SNF COVERAGE

HCFA provided medicare waivers and entered into contract with Blue Cross of Oregon and Blue Cross of Massachusetts in 1977 to conduct demonstrations in eliminating the 3-day prior hospitalization requirement for SNF coverage to determine whether a waiver of the 3-day requirement would result in lower overall costs for both the patient and the medicare program. In addition, an attempt will be made to determine if the 3-day requirement ordinarily imposes a burden on medicare patients who may need SNF care but not hospital care.

The SNF benefit included in medicare part A to provide a lower-cost alternative to extended hospitalization. The requirement, of a 3-day hospitalization prior to admission to an SNF, imposed by the statute to limit SNF benefits to persons who need continuing care after hospital treatment. The requirement also ensured that medical conditions and needs of medicare patients admitted to SNF's have been given adequate medical appraisal prior to admission. The Senate Finance Committee recommended that the Secretary of HHS conduct experiments to determine the effects of eliminating or reducing the requirement.

The experimental phase of the projects, which began in the spring of 1978, will continue through 1980. It was hypothesized that the 3-day prior hospitalization requirement has resulted in unnecessary hospital stays for medicare beneficiaries who could effectively use less costly SNF care without hospitalization. Nursing home utilization and quality of care also will be studied. Under the project approximately 28 facilities in each State have participated in the experimental part of the demonstrations admitting a total of 970 patients during the first 2 years of the project. During the experiment all other criteria involved in the medicare SNF level of care decisions remained unchanged. The utilization of the waiver option in Massachusetts and Oregon was low compared to the HCFA

Office of the Actuary's national estimate of a 25-percent increment in SNF utilization. The Oregon waiver project accounted for 7.2 percent of the Medicare SNF utilization in the demonstration period; for Massachusetts it was 11.5 percent. Since some patients involved would have gone to the hospital and then transferred to SNF care afterward, the actual increment in nursing home utilization due to the waiver is somewhat less than these figures. The utilization rates for the two States were 0.38 and 0.23 waiver admissions per bed in Oregon and Massachusetts, respectively; the number of waiver admissions per 1,000 medicare enrollees with 1.3 in Oregon and 0.7 in Massachusetts. Both States had similar experience with respect to the length of stay. In Oregon, 79 percent of medicare covered stays were below 31 days in length; in Massachusetts, 69 percent were below 31 days. The average covered days under the demonstration varied between the two States: 26.6 days for Massachusetts and 20.5 days in Oregon.

The two States differed with regard to source of admission and patient diagnosis characteristics. In Massachusetts, 70 percent of all waiver admissions were internal transfers from a lower level within the institutions. Direct admissions from home represented another 22 percent, transfers from other nursing homes were 6 percent, and hospital transfers were 2 percent. The composition of admissions differed in Oregon; only transfers from other nursing homes (8 percent) were close to the percentage found in Massachusetts. Home admissions represented 40 percent of all admissions (Almost twice that experienced in Massachusetts), 39 percent of admissions were internal transfers (approximately half the rate for Massachusetts), and hospitals were involved in 13 percent of waiver admissions.

Patient diagnosis categories differed for the two States. While fractures and amputations accounted for 27 percent of all admissions in Massachusetts, Oregon patients accounted for only 5 percent of admissions in these categories. The reason for this difference can be explained partly by the presence of three chronic rehabilitation hospitals in the Massachusetts demonstration, two of which were entirely rehabilitative in their orientation; there were no facilities of this type in Oregon, which is more typical of the Nation.[1] The home admissions in Massachusetts occurred primarily in these rehabilitative facilities (73 percent of all home admissions), and the remaining home admissions were dispersed throughout the free-standing SNF's. Excluding the rehabilitation hospital cases, home admissions accounted for only 6 percent. This difference in home admissions between the two States was largely attributed to the better awareness of the demonstration by Oregon physicians and their more favorable attitude toward nursing homes.

The most important aspect of these data is that the numbers of demonstration admissions over the 2-year experimental period are small in both States, 545 in Massachusetts and 425 in Oregon—11.5 percent and 7.2 percent of Medicare SNF utilization in each State, respectively. These utilization rates raises a key issue for evaluation: Can the same moderate level of utilization be expected if the program is expanded nationally, or is it an artifact of either the peculiar environment of each State or the way in which the demonstration was implemented.

Each demonstration has been explored preliminarily in terms of its environment and special characteristics with the intent of identifying specific factors that differentiate the two demonstrations and account for the utilization experience that was lower than expected. The low overall utilization can be attributed to the medicare SNF admission criteria, the physician's practice patterns and bed shortages. The major factor that would lead to increased utilization of the medicare SNF benefit in a nondemonstration setting would be a reduction in the stingency of the medicare SNF criteria themselves, or in their enforcement by intermediaries or PSRO's; however, this reduction would affect direct entry and prior hospital stay entry equally. The degree to which this and other factors change or are not present nationwide will alter the utilization in a nondemonstration setting.

Finally, not all increases in medicare SNF utilization led to reductions in hospital utilization. Evaluation interviews suggested that between 35 and 67 percent of the waiver patients probably would have entered a hospital if the waiver option had not been available. Thus, it appears that the waiver option will result in some increases in medicare SNF costs, but the degree to which these will be offset by saved hospital stays is not clear and needs further analysis. The cost analyses will assess the cost of the waiver with respect to medicare reimbursement for SNF care and will estimate the potential hospital savings to assess the net cost of the waiver of the 3-day hospitalization stay prior to SNF admission requirement.

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[1] Of the 68 chronic rehabilitation hospitals in the Nation, six are in Massachusetts.

The evaluation contract was awarded to Abt Associates in September of 1979. Final reports from the demonstrations will be available in late 1981.

ON LOK COMMUNITY CARE ORGANIZATION FOR DEPENDENT ADULTS

HCFA has granted medicare waivers to the On Lok Senior Health Services to provide reimbursement for the delivery of a comprehensive health and social service package to an elderly population in the Chinatown-Northbeach area of San Francisco. This project will demonstrate the feasibility of a capitation system of reimbursement for the elderly in an HMO-type organization. The Office of Direct Reimbursement (ODR) is the fiscal intermediary for the demonstration. In addition, funding for the development and study of On Lok's CCODA is provided by a grant from the Administration on Aging.

The objectives of this demonstration are: To develop and operate a centrally funded and administered community care system; to measure the impact of capitated, decategorized funding on utilization, quality and cost of services; to contrast the management efficiencies of the model with those of other systems; and to develop actuarily sound budgeting methods for medical and social needs.

The demonstration is now in its second of 4 years. On February 1, 1980, inpatient services (hospital and skilled nursing facility) provided under contract were added to the package of outpatient services that was provided the first year of operation. These latter services include in-home services, portable meals and transportation, as well as a full array of health and social services provided in On Lok's two day health centers and one social center by physicians, nurse practitioners, registered nurses, social workers, and physical, recreational and occupational therapists. An intake and assessment team comprised of representatives of each discipline together with the participant, develops a plan of care based on the participant's needs. These needs are identified by a physical examination and an assessment that includes functional and mental status, as well as environmental and financial elements. The plan is carried out by the staff and is updated as the need arises and after quarterly reassessments. Specialized services such as dental care, eye examinations, surgery, etc., are provided by the specialists under contract to On Lok .

All participants who are admitted to the CCODA are judged by the intake and assessment team to meet ICF and SNF admission criteria. This judgment is verified through an independent certification by a medicaid field representative from the California Department of Health Services.

Funding for all services for participants is provided on a cost basis under medicare waivers. With increased cost experience, a more accurate prediction model will be developed to estimate inpatient utilization and total medical expenditures. This model will ultimately provide the capitation rate of reimbursement. Currently the per capita cost is $27.95 per day ($20.47 outpatient, $7.48 inpatient).

The role of the research team, funded under the AoA grant, includes the development and testing, in conjunction with the On Lok service staff, of the numerous computerized systems required to manage the CCODA and its diverse functions. Through On Lok's information management system, as each system becomes functional its management is transferred to the CCODA staff to replace a manual system. The intricacies of scheduling for all services, transportation, meals, etc., is one example of this role. Others include data collection and analysis activities.

A comparison group study is underway to assess the impact of the CCODA program on the quality and cost of long-term care, as compared to a matched control group of community cohorts who are receiving services through the traditional long-term health care system. The research design for assessing participant cost impacts of the CCODA program is a pre/post comparison group region. For each sample participant admitted to the CCODA, a matched individual from outside of the On Lok catchment area is selected. The total sample size will be 200 (100 CCODA participants and 100 matched controls). To date, approximately one-quarter of the sample has been selected. Analysis of the selection strategy and equivalency of the groups is being carried out.

HCFA is evaluating the On Lok CCODA through the cross-cutting evaluation of its long-term care demonstrations. This evaluation contract was awarded to Berkeley Planning Associates in September 1980.

SKILLED NURSING PHARMACY SERVICES—CAPITATED REIMBURSEMENT

A grant was awarded in 1979 to the California Department of Health Services to conduct a pilot project on capitated reimbursements of drugs for medicaid patients in SNF's, under the authority of section 1115 of the Social Security Act. The objective is to improve the drug regimen received by medicaid SNF patients which should improve the overall quality of care and reduce costs.

The California State Department of Health Services (DHS) currently administers a program of medical assistance under title XIX of the Social Security Act. The program provides a broad range of medical services to a beneficiary population that is predominantly categorically linked. By and large, medicaid pays for these services on a fee-for-service basis. Approximately 2.5 percent or 67,500 of the nearly 3 million beneficiaries receive their care in skilled nursing facilities (SNF's). Medicaid payment for health care for these beneficiaries is made to the individual provider of service, e.g., skilled nursing facility, physician, dentist, physical therapist, pharmacist. To control utilization of pharmacy services, medicaid employs a closed formulary, that is, a specified list of covered drugs, with prior authorization required for nonlisted therapeutic agents. In addition, both minimum quantities per prescription and minimum days supply per prescription are required for certain medications unless the prescription represents the initial order or has been prior authorized for a smaller quantity or duration of therapy. Minimum quantities commonly are required of drugs used for chronic medical conditions, and the minimum days supply requirement commonly apply to certain drugs dispensed to patients in SNF's. Current costs of pharmacy services for SNF inpatient average approximately $26 per patient per month. To determine if there are ways that the current expenditures for drugs for SNF patients in the medicaid program can be reduced, the California State Legislature enacted Assembly Bill 1395. The legislation authorized a pilot project wherein pharamacists would be reimbursed on a capitated basis for pharmacy services provided in SNF's.

The project proposes to establish capitation rates for 30 selected SNF's based on 30 pharmacies' experiences with those facilities. The monthly capitation rate will be calculated for each facility and will be paid to the pharmacy in advance for each medicaid patient served by that pharmacy in the following month. In addition, pharmacists who participate will be granted the authority to approve nonformulary drugs necessary for the treatment of the patients.

Participants will be selected to reflect the geographic and bed size distribution of nursing homes in the State. Contracts will be prepared to establish project requirements with the participating pharmacies. A group of pharmacies and skilled nursing facilities will be selected for comparison purposes. The project will be a 3-year effort with a 1-year precapitation period for selection of participants, baseline data collection, rate determination, and the development of the evaluation methodology. A 1-year period of capitation will then commence, followed by analysis and reporting of the results.

Capitation rates will be determined by dividing the prior year's medicaid expenditures for drugs in the facility by the number of patient months for which the facility was paid by medicaid. This figure will then be increased by an inflation factor for the year of the demonstration to account for increases in ingredient costs and to achieve parity with pharmacies serving Medicaid beneficiaries costs and to achieve parity with pharmacies serving Medicaid beneficiaries on a fee-for-service basis. In order to protect the participating pharmacies against excessive prescribing practices, the project will incorporate an upper limitation on risk. While the final figure will be related to the actual utilization levels of the pharmacy/facility, Department of Health Services staff anticipate that this risk amount will be in the vicinity of an average of two prescriptions per patient per month or an equivalent dollar amount. Any expenditures above this limit will be reimbursed by the Department on a fee-for-service basis to the participating pharmacies.

Pharmacists will be required to submit an invoice monthly, in advance, listing the names and medicaid ID numbers of those patients for whom the capitation rates are being claimed. In those cases where beneficiaries are reported to the department and are ultimately determined to be ineligible, reconciliation will be made by offsets to future capitation payments. Submittal of a current label or copy of the ID card for the month in question will satisfy eligibility questions. Participating pharmacists will be required to submit claim forms for data collection but not payment.

The project will allow the pharmacist to bypass the usual utilization controls of the medicaid program and to exert his professional judgment to a maximum degree, consistent with a high quality of care. Minimum quantity, minimum days' supply, 4/75 audits, and diagnosis restrictions will all be waived for the patients served under this project.

The pharmacist will be authorized to approve nonformulary drugs. However, in those instances when the pharmacist does not feel that the drug is necessary, the service can only be denied by the medicaid consultant. The department and the pharmacy association both feel that the professional arguments that may be raised against use of any particular medication will probably provide adequate justification for the consultant to support the pharmacist's position. This feature is built in, however, to insure against obvious underutilization on the part of the pharmacy and to enhance the professional relationship between prescribing physicians and pharmacists.

A two-part evaluation of the results of this project will be made. The department will conduct an evaluation of the changes in costs and utilization of services which result, if any. A second evaluation will be performed by outside consultants under contract, utilizing a multidisciplinary team of physicians, pharmacists, pharmacologists and nurses to evaluate the professional decisions involved in the TAR approval process as well as the overall quality of care received by the patients.

THE SOCIAL/HEALTH MAINTENANCE ORGANIZATION CONCEPT

A 3-year planning grant was awarded to the University Health Policy Consortium at Brandeis University in spring of 1980 to develop the concept of a social/health maintenance organization for long-term care. The social/health maintenance organization is a capitation financed delivery approach to meet the needs of the disabled and/or elderly. It is designed to address two of the most pressing problems in long-term care: (1) The fragmentation of services, and (2) the fragmentation of funding sources. The concept promises to integrate health and social services as well as acute care services.

The objectives of the planning grant are multifaceted and include the following: (1) Provide technical assistance to several possible demonstration sites; (2) develop the methodology for estimating utilization rates and for calculating costs and capitation rates; (3) coordinate development of the data system and evaluation plans to insure maximum test results; (4) develop criteria for selection of the demonstration sites; and (5) link the evaluation of social/health maintenance organizations to other long-term care demonstrations.

A social/health maintenance organization (S/HMO) is an approach to the organization of health and social services in which an elderly population, including those at high risk of institutionalization, is voluntarily enrolled by a managing provider entity into an integrated service system. All basic acute hospital, nursing home, ambulatory medical care services and personal care support services, including homemaker, home health, and chore services would be provided by or through the S/HMO at a fixed annual prepaid capitation sum. Other offered services would include emergency psychiatric, meals (home delivered and/or congregate), counseling, transportation, information and referral. The provider either may employ staff or establish contracts with other providers for the services. In the S/HMO model, financial, programmatic, case decision-making and management responsibility rests with the provider entity. The S/HMO provider will share risk for service expenditures and will be responsible for brokering other needed services not covered but which are available from other community providers. Financial risk is defined as absorption of agreed-upon costs which exceed a capitation agreement.

In comparison with other models, the S/HMO integrates health and social services under the direct financial management control of the provider at the point of services delivery. The success of conventional HMO's with medicare contracts and of other managed systems of care (e.g., Triage and Monroe County models) have suggested the possibility of expansion to an S/HMO system model.

In the proposed demonstration, the S/HMO will be geared to serve persons from a targeted elderly population ranging from the ambulatory nonimpaired aged to those who are extremely impaired. Inclusion of the well-ambulatory permits preventive activities for a population which feeds both hospital and nursing home utilization. Early management is expected to result in a delay or reduction in nursing home care. For such a population survey data indicate that approximately 55 percent are ambulatory and well, 25 percent are ambulatory with modest home care needs, 15 percent are living at home with severe impairments, and 5 percent are very impaired whether housebound or in nursing homes. While the S/HMO is expected to have all four groups represented, the proportion enrolled will depend upon the attractiveness of the program to different groups and the intake procedures established by the S/HMO.

Financing of the S/HMO will flow from some combination of public funds (e.g., medicare, medicaid, and title XX), as well as from private payments, deductibles and potential private third party payors. Reimbursement would be on the basis of prepaid capitation.

The S/HMO offers incentives to all involved parties. Incentives to the provider organization, for example, include improved cash flow, reduction in the cost of administering third-party billing mechanisms, flexibility in program innovation, financial incentives through negotiated rate ceilings and flexible savings arrangements, greater organizational stability, and growth potential in the long-term care marketplace. Public authorities gain by harnessing HMO control methodologies to long-term care. The uncontrolled, or diffuse long-term care costs can be addressed systematically through an integrated financing plan with provider risk-sharing and reduced administrative complexity. Consumers will benefit by having a single-entry access to a wider range of services. These services will be provided in an integrated manner, thus reducing the need and costs of shopping around. Paperwork usually associated with medicare (e.g., assignments) will be eliminated.

It is hypothesized that the S/HMO will reduce the number of expensive institutional days for enrollees as well as encourage significant changes in utilization patterns.

Three S/HMO demonstration sites, to be selected, will provide a strong comparative evaluation of different S/HMO modes of organization. They will all use common assessment instruments, comparable experiment populations, compatible management information systems and a common evaluation strategy. The demonstrations will provide answers to questions about cost/benefit effects of a S/HMO; the effects of integrated care on the elderly and on service costs; the administrative feasibility of the S/HMO model compared with the fee-for-services model; and the effects on quality of care.

This grant is in the preliminary planning stage at this time.

QUALITY ASSURANCE

SURVEY-BY-EXCEPTION (SBE)

In July 1980, a section 1115 waiver-only quality assurance grant was awarded to the Massachusetts Department of Public Welfare. The purposes of this 18 month project are to: reallocate surveyor time so that facilities with the greatest certification compliance problems can receive additional consultation and technical assistance by the surveyors; and improve the quality of care in skilled nursing facilities (SNF's) and intermediate care facilities (ICF's).

This project will test an experimental facility survey process in medicaid and medicare facilities. The medical review (MR) and independent professional review (IPR) patient survey process will be performed as usual. A facility screening instrument has been developed by Massachusetts and will be pretested for reliability and validity before use in the demonstration.

Methodology

The facility survey is a modification of the screening survey developed by the Wisconsin quality assurance project. The design for the demonstration involves classifying facilities into three groups, based upon the performance of facilities on annual surveys for the preceding 3 years.

The Massachusetts long-term care information system (LTCIS), a management information system containing the results of all facility surveys since 1976, allows the aggregation of survey results at the facility level, so that survey results can be compared across facilities. The criteria for facility classification are as follows:

(a) Screening survey group.—Compliance scores of 95 or above on annual inspections for 3 calendar years prior to the inspection date (classified as outstanding).

(b) Abbreviated survey group.—Compliance scores of 85 or above for the past 3 calendar years (classified as acceptable).

(c) Full survey group.—Compliance scores below 85 for the past 3 calendar years (classified as unacceptable).

The demonstration is planned as a 2X2 experimental design with test facilities in outstanding (95 score and above) and acceptable (scores between 85 and 95) groups assigned randomly to the traditional method of survey and the SBE method.

The design calls for 120 of the 160 facilities in two geographic areas, the northwest and southeast sections of the State, to be assigned to the four cells of the design—60 will be eligible for SBE and 60 will receive the traditional survey.

Hypotheses to be tested include:

(1) Quality of care in the screening and abbreviated survey facilities in the experimental groups will increase or remain constant relative to screening survey and abbreviated survey facilities in the control group.

(2) Quality of care will improve in the full survey facilities.

(3) Time spent on certification visits will decrease in facilities in the abbreviated and screening survey visits.

(4) Time spent on certification visits will increase or remain constant in the poor performance group.

(5) The number of interim visits, followup visits, and consultation visits, and the time spent on such visits, will increase in each of the three groups.

(6) Provider attitudes toward the State survey agency will be more favorable in facilities participating in SBE.

The demonstration will be initiated October 1, 1980, following completion of pretesting and compliance with conditions attached with the notice of grant award.

This demonstration will be evaluated by an independent evaluator chosen by HCFA to evaluate all of the survey/certification related demonstrations.

NURSING HOME QUALITY ASSURANCE PROJECT (QAP)

The Wisconsin Department of Health and Social Services is in the third of a four year 1115 waiver-only project that proposes to improve the quality of care in nursing homes using an experimental survey and certification methodology. This demonstration is based on the premise that the State should reallocate surveyor time so that more time is spent in nursing homes that are cited as having deficiencies and less time in nursing homes providing good care.

Project Objectives

The primary goal of the project is to improve the quality of care in nursing homes in the demonstration areas using cost-effective techniques which reallocate the State's resources.

1. To increase the efficiency and effectiveness of the facility review process, QAP:

(a) Uses a screening technique which allows teams to separate homes into three categories: homes performing well; homes with minor problems likely to be resolved with consultation; and homes with one or more serious problems requiring detailed analysis for possible negative action.

(b) Omits the full facility survey except where indicated by a history of problems or after using the new facility screening technique.

(c) Involves nursing home administrators and rehabilitation specialists in the facility survey to provide a broader base of knowledge for the evaluation.

(d) Trains survey staff to collect court-worthy data when negative action is indicated; and

(e) Schedules survey visits at less predictable and more frequent intervals to allow for collection of more accurate data.

2. To increase the efficiency and effectiveness of the Medical Review (MR) and Independent Professional Review (IPR) of patient care, QAP:

(a) Uses a statistical quality control methodology to choose a stratified sample of patients for *intensive* review, rather than performing a cursory review of all patients currently in the home.

(b) Reallocates staff time and focus to an in-depth evaluation of the home's *system* for identifying and meeting patient needs.

(c) Omits the full MR and IPR survey except where indicated by a history of patient care problems or after using the new patient sampling technique; and

(d) Provides feedback to the facility survey process by citing deficiencies and by documenting cases of poor patient care for court use.

3. To improve the quality of nursing home care by matching the most appropriate actions for resolution with the problems discovered through the facility survey and patient review, OAP:

(a) Has developed criteria for quickly choosing corrective actions from a list ranked by severity.

(b) Has added new options to the list of correction/enforcement actions, including consultation with survey team members and contracted technical assistance; and

(c) Has provided more immediate feedback to homes detailing deficient areas of patient or institutional management discovered through the evaluation process, especially for homes evaluated as needing enforcement action.

Since these last three elements are considered essential in any quality assurance system, they are used in both control and experimental sites. The experimental design separates the effect of these changes from those caused by the experimental facility and patient review processes.

Methodology

[illegible] Bureau of Quality Compliance, Wisconsin Division of Health, is demon[illegible] two new approaches to the control of quality in nursing homes. These approaches deviate from traditional State and Federal requirements. The first requirement [illegible] that a nursing home be evaluated for compliance with applicable State and Federal regulations at least annually. The second requirement is that every medical assistance nursing home resident be evaluated at least annually for appropriat[illegible] and level of care.

Facility screening.—In place of existing requirements for annual surveys of nursing homes, a screening survey designed to quickly identify problems in critical areas affecting quality of care is being tested. Based on problems found during screening, decisions for further action are made ranging from informal consultation to decertification. The time saved through this screening process is allocated to consult with homes where appropriate and to more rigorously pursue enforcement in homes that are endangering the health of their residents.

Sampling patient review.—In place of existing requirements for review of medical assistance recipients in nursing homes, a scientifically chosen 10 percent sampling of all patients in the home are intensively reviewed. As in the facility screening process, decisions for further action are based on problems found during the careful review of the sample of patients. State surveyor time saved by not examining all patients is devoted to more extensive consultation and enforcement.

In July 1978, during the first phase of the demonstration, 122 facilities (SNF's and ICF's) in a rural area were studied. A 2 x 2 factorial design of the treatments, facility survey and patient evaluation, was employed in the rural site. The two options for facility "treatment" are the old full survey and the new screening survey; the two options for the patient "treatment" are the old 100 percent medical review and the new patient sampling technique.

In the second phase of the project, an additional 40 homes in a large urban area were added to the demonstration. In half of these nursing homes (20), the screening survey and patient sampling techniques were used and in the remaining 20, the old full survey and 100 percent medical review were carried out. In addition, another group of 20 homes were selected as control homes in the urban area.

Two additional changes were made in the second year which impacted on the demonstration methodology, they were:

(1) HCFA approved a waiver of the Life Safety Code so that a screening survey instrument could be used by the engineer/architect.

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(2) Health Standards and Quality Bureau approved receiving less than the full report for title XVIII certified facilities which resulted in the inclusion of these facilities in the demonstration.

In the last phase of the demonstration, 40 additional facilities were added to the sample. These facilities are located in a mixed rural/urban area of the State. The methodology has been slightly changed in the last phase to further eliminate the possibility of surveyor bias. In these areas, separate survey teams have been assigned to each treatment cell. One team utilizes the screening survey and patient sampling methodology and the other, the full survey and 100 percent patient sampling.

With this last expansion, the demonstration project includes 31,000 resident/patients and 281 (59 percent) of the State's nursing homes.

Findings to Date

(1) The total time for survey and certification visits using the screening survey and 10 percent sampling of patients for MR/IPR is 2 days in homes 100 beds or less, while the traditional methods in homes of the same size require 15 working days.

(2) The State survey staff and nursing home administrators and staff have positive attitudes about the screening survey and sampling technique.

(3) The number of nursing home administrators serving on the screening surveys has increased but has not yet reached 100 percent.

(4) Surveyors are making increased use of the option to switch from the screening survey to the traditional method. The most common reasons cited are a poor survey record, new administrator, or director of nursing.

(5) Surveyors in the rural districts make more frequent use of the surprise visit than those in the urban areas.

(6) Surveyors using the new methods are spending proportionately more time on facility assessment than when using the traditional method: somewh[illegible] time on resident assessment; and only a slightly greater proportion o[illegible] followup.

(7) When the new methods of survey and certification are used, [illegible] more class A violations (probability of death or injury to a patient) and slightly less class B (direct threat to health and safety) and class C (does not threaten health and safety) violations were found.

(8) Surveyors using the new methods make more frequent use of a variety of State followup actions, i.e., consultation, special advisor, and return to followup.

(9) There is a lower percentage of patients observed to be at an incorrect level of care using the sampling methodology. However, after reviewing the history of facilities in the study, the QAP findings reflect preexisting differences in these homes.

A grant for an independent evaluation of the demonstration was awarded in July 1980, and should reflect a more precise analysis of the data.

HOSPICE

MEDICARE/MEDICAID HOSPICE DEMONSTRATION

Background

The growth of hospice care in the United States is a relatively recent phenomenon aimed at helping terminally ill patients live with maximum comfort and minimal disruption to routine activity. Hospice emphasize palliative care for the control of pain and other symptoms of terminal illness. In addition, the hospice concept of care views the patient and family as a single unit of care. Many hospice patients are able to remain at home with their families while continuing to receive services. Hospices use a multidisciplinary approach to deliver social, psychological, medical, and spiritual services, employing a broad spectrum of professional and voluntary care givers.

The medicare and medicaid programs do not currently recognize hospices as a separate provider category, although some hospice organizations are participating in Federal programs within existing provider classifications (e.g., hospital, skilled nursing facility, and home health agency). Some hospice services, such as drugs used in the home and bereavement visits to the patient's family, are not reimbursable under medicare. State medicaid programs have differing coverage of

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hospital, nursing home, and home health services, and many States do not cover certain services integral to hospice care.

Project Description

Because this concept of care is relatively new in this country, HCFA has implemented a hospice demonstration project which permits the waiver of certain statutory and regulatory requirements in order to allow coverage of hospice services provided to medicare beneficiaries and medicaid recipients. No discretionary grant funds have been awarded for this project.

The demonstration includes a 24-month experimental phase during which hospice services will be reimbursed, and a 6 month, wind-down period. It is likely to provide a basis for considering more flexible approaches to medicare and medicaid reimbursement of hospice services. The operational phase of the demonstration began on October 1, 1980.

Twenty-six sites have been selected for participation in the HCFA hospice demonstration program. The decision to choose these 26 was based on the need for evaluation data that would reflect urban and rural differences and variations in hospice provider types. Of the demonstration hospices, 11 are hospital-based, 11 are home health agency-based, and 4 are freestanding. All 26 hospice organizations are either certified home health agencies (HHA's) or have contractual arrangements with certified HHA's to provide home health services. Some also have the capability of providing inpatient hospice services. There is at least one demonstration site in each of the 10 Health and Human Services regions.

For 24 of these hospices, medicaid State agencies have also agreed to participate in the project and will reimburse for services to medicaid recipients.

Under the demonstration, the hospices will serve patients who have (1) a life expectancy of 6 months or less, (2) a primary care giver, such as a relative or friend, who is available to provide simple personal care and emotional support on an around-the-clock basis, and (3) entitlement to hospital insurance benefits (medicare part A) and supplementary medical insurance benefits (medicare part B) and/or eligibility under medicaid.

Participating hospices may be reimbursed under the demonstration for a number of items and services not currently covered by medicare. Examples include: outpatient prescription drugs, institutional respite and home respite services (primary care giver relief), visits by dieticians and homemakers, supportive and counseling visits to hospice patients during occasional hospital stays, continuous care (by nurses, home health aides, or homemakers) on a shift basis in the home, certain self-help devices such as safety grab bars, inpatient hospice care, and bereavement services to family members.

The project evaluation is being jointly supported by HCFA, the Robert Wood Johnson Foundation, and the John A. Hartford Foundation. HCFA and the Foundations have selected Brown University, Division of Biology and Medicine, to conduct an independent study of the project in terms of cost, use, and quality of care provided to hospice patients and their families. To more clearly understand the effects of hospice care and of reimbursement for hospice care, HCFA and Brown University will also gather information on other groups of terminally ill patients, including one selected comparison group of patients served by hospices outside the demonstration and another selected comparison group of patients served by hospitals and cancer centers which provide conventional medical care.

The evaluation will focus on: (1) Identification of the types of hospice services provided to terminally ill medicare and medicaid beneficiaries and a determination of the cost of providing those services; (2) identification of the types of services provided to terminally ill patients by conventional modes of care and a determination of the cost of providing those services; (3) comparison and analysis of the cost of services provided in-home and in inpatient settings by the demonstration hospices and conventional modes; and (4) assessment of the adequacy of the care received.

The Office of Direct Reimbursement (ODR), Bureau of Support Services, HCFA, serves as the fiscal intermediary to process all medicare claims submitted by participating hospices. Medicaid hospice claims from the participating States will either be processed by their own fiscal intermediaries or by ODR. For demonstration services provided to medicare beneficiaries, ODR will reimburse the hospices on the basis of reasonable cost subject to retrospective cost reimbursement.

Relations with PSRO's

Impatient hospice care may be necessary to closely monitor a patient's pain and symptoms. This type of care may also be recommended for a short period of time when there is no one in the patient's home to assist the patient, or the family needs a rest from the routine of caring for the patient (respite care). This nonmedical hospitalization presents the possibility of conflict with PSRO review. To avoid a denial of payment for these hospice patients, HCFA's Health Standards and Quality Bureau (HSQB), which is responsible for coordinating PSRO activities, has suggested two options to ensure compatibility between the demonstration goals and the PSRO program. The first option encourages the PSRO to continue its concurrent review by developing criteria consistent with the project goals. In recognition of time and budgetary constraints, however, the PSRO has been given the flexibility to focus out on these patients. Under this second option, the PSRO would only maintain a monitoring function. HSQB issued a transmittal to PSRO's which outlined these options.

INDIVIDUAL PROJECTS—NEW

COMMUNITY CARE ORGANIZATIONS

Illinois, Long-Term Care Voucher Experiment for the Elderly

The Illinois Department of Public Aid received a grant from HCFA in September of 1980 under section 1115 of the Social Security Act to test a voucher system of financing the personal care and maintenance services believed essential for elderly individuals with moderate to severe functional impairment, in conjunction with the State Department on Aging.

Clients participating in this project will be able to purchase services necessary to maintain themselves in their own homes from any provider agency including voluntary agencies, "for-profit" agencies, project case management aides, informal providers, families (excepting the spouse), and neighbors. The amount of each client's voucher will be based on his/her degree of functional impairment.

The project will establish a centralized case management system for identifying resources, assisting in service planning, advising clients in the use of the voucher and monitoring the receipt and quality of care. Case managers will work with clients and their families on developing care plans but final decisions about what services to purchase and which provider to use will be left to the client, preserving a strong emphasis on client freedom of choice. For services that cannot be purchased through the voucher, the case manager will refer to appropriate resources, arrange for and monitor services.

Services to be provided by the project under waiver which are not otherwise covered by medicaid are: homemaker services, chore services, meal services, and adult day care.

The projects will operate in one site: Joliet Township.

A major research objective of this project is to determine the impact of the voucher on informal supports. The research design calls for the investigation of costs, utilization and client outcomes through an experimental design, and analysis of case management and program administration through a nonexperimental design. In addition the project will investigate the effectiveness of using a predetermined client cost ceiling through the voucher as a way of controlling long-term care costs.

Other overall project objectives are:

—To improve the coordination of and client access to community long-term care services by establishing a centralized case management system.

—To improve the match between identified clients needs of functionally impaired elderly and the use of community services.

—To investigate the costs, benefits and administrative feasibility of providing long-term care benefits under this system.

—To investigate the impact of expanded publicly financed long-term care benefits on informal systems of care.

The project is currently carrying out planning and preoperational tasks.

Georgia, Alternative Health Services

In July 1976, under the authority of section 1115 of the Social Security Act, the Georgia Department of Medical Assistance embarked on a demonstration project in two of the State's human resources districts (covering 17 counties). The project offers alternative services to nursing home care for persons who would otherwise be placed in institutions. The model is built on a centralized single point of entry into all service systems. In addition to regular medicaid financed health services, the demonstration offers three alternative services; adult day rehabilitation, home delivered services and alternative living services (e.g., personal care, adult foster care, boarding services and congregate living arrangements). Currently, the program serves 1,385 clients, approximately 1,040 have been referred to the experimental group and 345 to the control group for research purposes.

All potential alternative health services (AHS) clients receive a health and social needs assessment prior to enrollment. Along with self-referrals, the project receives referrals from hospitals, the county department of family and children services and the Georgia Medical Care Foundation, the project's independent utilization review contractor. Clients who appear to be eligible for services are interviewed by designated caseworkers from the county who administer the client assessment interview which collects health and social information on the client. Following the interview, the caseworker obtains the relevant medical data from clients physicians and additionally significant social information on family and support systems. The information gathered by the caseworker is reviewed at a team conference consisting of an AHS nurse and social worker and designated caseworker. The team uses the State maximum units of service guidelines to identify patients who require more intensive care than the project can provide. After the conference, the caseworker notifies the client of service recommendation or control assignments. (Three out of every four clients determined appropriate for the project are randomly assigned to AHS service groups with the fourth assigned to a control group. Clients in both groups are tracked for the duration of the project.)

Once a patient is accepted to participate in the project he or she is referred to appropriate providers. A face-to-face interview is conducted by the provider who notifies the team within 5 days whether or not the services recommended are adequate for the client. The provider then indicates the services to be offered, the frequency of services and provides a justification for not providing services recommended by the assessment team. Any changes in the client's care plan must be approved by the team.

Standard contracts have been negotiated with a large number of alternatives services providers which include: (1) prior agreement on specific expenditures and cost allocations; (2) a line item budget which the provider cannot exceed; and (3) a system which allows a provider to retain unexpended funds for use in program expansion.

An evaluation of the project is being undertaken by Medicus Systems Corporation under contract to the grantee. Medicus has participated and reviewed all aspects of the project including the technical research aspects and the management system. In particular, the evaluation will focus on costs, utilization, health impact and effectiveness.

Preliminary analysis of the effectiveness of project services indicates that project services can reduce the rate of client mortality, particularly among those at higher risks of entering a nursing home. For clients judged to be at high risk of entering a nursing home, 18 percent of the service group died, compared to 45 percent of the control group, within 12 months of enrollment in the project. Additional preliminary findings indicate that 42.6 percent of the clients have received home delivered services, 14.7 percent have received adult day rehabilitation and 2.8 percent have received alternative living services.

The final project report is expected in the spring of 1981.

The Georgia State Legislature has appropriated funding for the expansion of the AHS program so that it may be adopted statewide (over a 3-year period) as part of the State medicaid plan. Efforts to phase in AHS statewide began in August 1980. The program is currently working on the transition from a demonstration project to a statewide program and establishing ongoing linkages with providers and agencies. In addition, the project is conducting audits of providers. Together with the evaluator. AHS is working on developing a methodology to convert the current financial data base which is in a charge-based format suitable to a demonstration, to a cost-based format, more suitable to the State medicaid program.

REIMBURSEMENT

CAPITAL INVESTMENT IN NURSING HOMES

In August of 1980 the West Virginia Department of Welfare was awarded a section 1115 grant. This allowed waiver of the current methodology for determining capital costs included in the medicaid reimbursement of skilled nursing facilities and intermediate care facilities. The basic objectives of this demonstration are as follows:

To determine whether the proposed reimbursement system results in the production of satisfactory patient care within the operating cost standards.

To determine whether the proposed system results in lower reimbursement rates when compared with a system of reimbursement based on historical costs for all service factors (for example, a medicare formula).

There is reason to believe that operating cost control by cost center is preferable to an aggregate operating cost cap, but the data required to evaluate this hypothesis are not currently available. This project will, therefore, focus upon the investment component and the total reimbursement rate under the following operational assumptions. Functional and physical variances from the model facility standard result in operational and nursing services deficiencies, inefficiencies, and diseconomies. Quality of care is assured and verified through review of the monthly long-term care services invoices and quarterly nursing services audits. Both the rates of reimbursement and the manner in which they are determined impact significantly upon investor confidence in the industry and upon the quality of services provided.

Since the advent of the medicare and medicaid programs, the requirement for a suitable, feasible, and acceptable means of determining the rates at which health services providers should be compensated has been at issue. Current Federal law (Public Law 92-603, section 247) provides ". . . for payment of the skilled nursing facility and intermediate care facility services provided under the plan (State medicaid plan) on a reasonable cost-related basis, as determined in accordance with the methods and standards which shall be developed by the State on the basis of cost finding methods approved and verified by the Secretary." In moving toward passage of section 249 of Public Law 92-603, the Congress indicated a concern about the effects of both underpayment and overpayment for medical care and services in long-term care facilities on the quality of care for patients. Furthermore, the strain on State welfare budgets imposed by rising prices for medical care and services in skilled nursing facilities has harshly focused realities underlying such concerns to bear upon the State programs. On the one hand, State programs realize that long-term care facilities which are not compensated for the real costs of providing services to medicaid patients will be under pressure to reduce the scope, quantity, or quality of care; to make their nonmedicaid patients absorb some of the costs of medicaid patients' care; or at worst, to refuse to accept medicaid patients. Furthermore, in areas which are not now adequately served by skilled nursing facilities and intermediate care facilities, underpayment may discourage investments in needed service capacities. On the other hand, overpayment provides little or no incentive for providers to employ the most efficient and economical methods for meeting the service requirements of their patients, resulting in reduced effectiveness for State medicaid long-term care budgets. Excessive institutional costs effectively constrict limited resources, thereby reducing the amount and quality of additionally needed goods and services.

The problem is, therefore, to develop and use approved cost-finding methods to establish the reasonable costs of skilled nursing facility and intermediate care facility services, and, on the basis of such cost-finding methods, to develop and use methods and procedures for payments on a reasonable cost-related basis. These methods and procedures must set payment rates which assure that all participating providers' reimbursement will be reasonably cost-related rates. Similarly, they must set payment rates which are derived and monitored through tractable and manageable administrative procedures; and set payment rates in a way which can be validated and acceptable to both the Secretary and the State.

Within this context, West Virginia will implement a three-component reimbursement system. The nursing services component will be compensated on the basis of actual nursing services required by and delivered to individual patients. The operating costs component will be compensated by cost center and facility class. Caps on operating costs will be derived from industry experience within the State. Incentives for efficiency and economy will be introduced through the operating cost component by encouraging costs less than the cost caps, with quality of care assured and verified. As a management incentive, the State will share with the facility any cost avoidance from efficient management which results in costs below established caps. That incentive will consist of allowing in the facility rate a percentage of the difference between actual facility cost and the established cost caps, provided such facilities meet all certification and quality patient care standards. The investment component of the new reimbursement system should allow for the reasonable costs of investments in long-term care facilities, including a reasonable return on the investment. A unique aspect of this system is the method for determining the allowance for value of the investment component (land, building, and equipment) of the reimbursement rate.

The standard appraised value (SAV) method establishes the value of the fixed assets *as a long-term care center*, thereby discouraging features which detract from or do not contribute to that function and encouraging functional utility. The model facility standard is drawn from Federal and State regulations and guidelines, and from accepted industry practice, and offsets the fundamental difficulty of the reproduction cost approach by providing a stable base for deriving consistent appraisals of long-term care properties.

The work to be undertaken in the first year includes the design and implementation of uniform accounting and reporting procedures, definition of the model facility standards, initial appraisals of all facilities, the evaluation of the appraisals and the establishment of a rate of return. This project has just begun, therefore, no findings are available at this time. It is hoped that this different method of reimbursing capital costs will discourage rapid turnover in facility ownership and encourage greater stability.

PUBLIC HEALTH SERVICE

ALCOHOL, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

NATIONAL INSTITUTE OF MENTAL HEALTH

INTRODUCTION

Five percent of the Nation's aged live in institutions. Of these about 12 percent are in mental hospitals with the remainder in nursing and other types of homes for the aged and chronically ill. The elderly comprise 6 percent of additions to State and county mental hospitals and 29 percent of the resident patients. Approximately 80 percent of those aged 65 and older who live in nursing and personal care homes have some degree of mental impairment. Only 3.8 percent of outpatient psychiatric service admissions are aged 65 and over. An estimated 10–25 percent of the aged in the community have some degree of mental impairment. The death rate for suicide among the elderly is highest at age 55 and over (19.9 per 100,000 as compared with 12.7 per 100,000 for all ages). Approximately 44 percent of all male additions aged 55 and over to inpatient services of State and county mental hospitals had a primary diagnosis of alcohol disorder.

THE MENTAL HEALTH SYSTEMS ACT OF 1980 (PUBLIC LAW 96–398)

A focus on the specialized needs of the elderly in the mental health service system was established in law in the amendments to the Community Mental Health Centers Act (Public Law 94-63). This focus was broadened and extended in the Mental Health Systems Act (Public Law 96–398) in which grants for mental health services to elderly individuals were authorized in section 204(a).

In passing the Mental Health Systems Act, the Congress found that despite the significant progress that has been made in making community mental health services available and in improving residential mental health facilities since the original community mental health centers legislation was enacted in 1963, unserved and underserved populations remain and there are certain groups in the population, such as chronically mentally ill individuals, children and youth, elderly individuals, racial and ethnic minorities, women, poor persons, and persons in rural areas, which often lack access to adequate private and public mental health services and support services.

Nearly all sections of the act have some relevance to the elderly, with key provisions contained in four of the sections.

Community Mental Health Center (Section 201)

Grants may be made to any public or nonprofit private community mental health center to meet the costs of operating such a center. A community mental health center (CMHC) may receive these grants for operation for up to 8 years. The definition of the program and services of a community mental health center is included in the law (section 101) and is similar in most respects to that defined by the CMHC Act. Section 101 does call for CMHC's to give special attention to chronically mentally ill.

Initially, a community mental health center must provide: Inpatient services, emergency services, outpatient services, assistance to courts and public agencies in screening persons being referred to State mental health facilities, followup care to the deinstitutionalized, and consultation and education services.

Within 3 years a community mental health center must provide: Day care and partial hospitalization services, specialized services for children, specialized services for the elderly, transitional halfway house services, and unless otherwise being provided in the mental health service area, alcoholism and drug abuse services.

The community mental health center is expected to obtain State, local, and other funds, fees, premiums, and third-party reimbursements. The amount of the Federal grant will not exceed the amount by which the aforementioned resources do not cover the total cost of operation of the community mental health center up to a certain maximum percentage of the cost of operation as follows:

Poverty area: first year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fiftn year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent. Nonpoverty area: first year, 80 percent; second year, 65 percent; third year, 50 percent; fourth year, 35 percent; fifth year, 30 percent; sixth year, 30 percent; seventh year, 25 percent; and eighth year, 25 percent.

The declining percentage and limit of 8 years for CMHC grants reaffirms the philosophy that the Federal role is to initiate services and for the community mental health center to obtain State and local funding, and third-party reimbursements to become financially independent.

Chronically Mentally Ill (Section 202)

Grants may be made to State mental health authorities, community mental health centers or other public or nonprofit private entities to provide mental health and related support services for chronically mentally ill individuals. No State, CMHC, public or nonprofit entity may receive more than eight grants under this section. A grant for a project in a mental health service area (formerly a catchment area) served by a CMHC, may be made only to the CMHC or the State mental health authority, unless the Secretary finds exceptional circumstances to indicate that the chronically mentally ill would be better served by another public or private nonprofit entity.

A project under this section must provide for at least the following:

—Identification of the chronically mentally ill in the area to be served.

—Assistance to individuals to obtain mental health services, medical and dental care, rehabilitation services, employment and housing and other services, enabling the individual to function independently of an inpatient facility.

—A case manager to assure that the individual receives such services.

—Coordination of mental health and related support services.

Grants may be made to State mental health authorities to:

—Improve the skills of personnel providing services to the chronically mentally ill.

—Coordinate State agencies responsible for mental health and related support services.

The amount of the Federal grant will not exceed a specific maximum percentage of the total cost of the program, as follows:

First year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent.

Elderly Individuals and Other Priority Populations (Section 204)

Elderly Individuals (Section 204 (a))

Grants may be made to any public or nonprofit private entity for services to elderly individuals. No entity may receive more than eight grants for the provision of services to the elderly. Each grant shall provide at least the following:

—Location of elderly individuals in need of mental health services.

—Provision of or arrangement for the provision of medical differential diagnoses to distinguish between the need for mental health services or other care.

—Specification of the need for mental health and related support services by the elderly.

—Provision of mental health and support services in the community including those individuals in nursing homes and intermediate care facilities and training for personnel in these facilities.

To the extent that a public or private nonprofit entity is already providing the aforementioned services grants may be made to it for any of the following:

—Assurance of the availability of personnel to provide or arrange for the provision of services to the elderly.

—Coordination of the provision of mental health and support services with the area agency on aging (as defined by the Older Americans Act) and other community agencies providing services to elderly individuals.

The amount of the Federal grant shall not exceed a specific maximum percentage of the total cost of the program as follows:

First year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent.

At least 40 percent of the funds appropriated for section 204 are to be used for projects to serve the elderly.

Mental Health Services in Health Care Agencies (Section 206)

Grants may be made to health care centers to provide mental health services to their patients. Two types of public or private nonprofit entities are eligible for grants.

(1) An entity which provides mental health services which includes at least 24-hour emergency, outpatient, and consultation, and education service and which has an affiliation agreement for the provision of health and mental health services.

(2) A health care center which has in effect an affiliation agreement with a mental health services entity as defined above. Section 203 says, "the term "health care center" includes an outpatient facility operated in connection with a hospital, a primary care center, a community health center, a migrant health center, a clinic of the Indian Health Service, a skilled nursing home, an intermediate care facility, and an outpatient health care facility of a medical group practice, a public health department, or a health maintenance organization."

An affiliation agreement includes the following:

—Description of the geographical area to receive mental health services.

—Provisions for at least one mental health professional to serve as liaison between the two parties.

—Provision of satisfactory assurances that patients referred will receive mental health services.

—Provisions for transportation.

A grant may be made to provide any one or more of the following:

—The costs of liaison or other professionals providing mental health services in the health care center.

—Mental health services provided by other personnel of the center.

—Consultation and inservice training on mental health services provided to personnel of the health care center.

—Establishing liaison between center and other providers of mental health services.

An entity may not receive more than eight grants under this section. The amount of the Federal grant will not exceed a specific maximum percentage of the total cost of operation as follows:

First year, 90 percent; second year, 90 percent; third year, 80 percent; fourth year, 70 percent; fifth year, 60 percent; sixth year, 50 percent; seventh year, 40 percent; and eighth year, 30 percent.

THE NATIONAL INSTITUTE OF MENTAL HEALTH

Aging, though long a program area of the National Institute of Mental Health (NIMH), has only received limited support. This has been changed in recent years to where the NIMH program has grown to assume major national and international leadership roles.

Recent events of significance in the development of the NIMH program include:

(1) August 1975. Establish the Center for Studies of the Mental Health of the Aging to *coordinate* Institute activities in aging.

(2) 1975–76. National planning conferences, one each in research, in training, and in services in mental health and aging were held to help establish the agenda for the Center.

(3) 1977. $2 million in the supplemental appropriation for fiscal year 1977 was provided to support research in mental health and aging.

(4) 1978. Report of the HEW Secretary's Committee on the Mental Health and Illness of the Elderly (mandated in Public Law 94–63), transmitted to the Congress.

(5) 1978. Report of the President's Commission on Mental Health, highlighting the elderly as a major underserved population published and implementation of recommendations begun.

(6) 1978. Center for Studies of the Mental Health of the Aging elevated from a coordinating unit to full operational status with responsibility for administering grants in research and training.

(7) 1979. Aging identified as a priority target population for clinical training initiatives, in line with recommendations of the President's Commission on Mental Health.

The Center for Studies of the Mental Health of the Aging (CSMHA) is the focal point in NIMH for aging programs. The major role of CSMHA is to stimulate, coordinate, and support research, training, and technical assistance efforts relating to aging and mental health. The Center staff contains eight professionals, four support staff, and one visiting scientist.

The formal establishment of a Center is indicative of substantial programmatic and administrative priority in a particular area. Consequently, this is not a step which is taken quickly. It involves, at a minimum, complete assessment of the Institute's program activities, evaluation of the knowledge base and state of a field, and active staff stimulation of the development of programs in research, training, and service. This report contains the documentation of the progress made by the Center for Studies of the Mental Health of the Aging in the development of its program.

PROGRAM ACTIVITIES

Activities of the Center fall into four categories: Research, research training, clinical/services training, and technical assistance. Each is discussed in turn.

A. Research Program

The Center supports those studies which have a primary focus on the mental health and illness implications of the aging process and of old age. It supports a wide-ranging, multidisciplinary set of studies which have both theoretical and policy or applied implications. These include:

1. Etiology, Diagnosis, and Course

Studies of the psychological, social, and biomedical factors (and their interplay) that affect mental health and mental illness in later life; clinical and diagnostic studies of the nature and types of mental disorders in later life; studies to assess and measure the extent of cognitive, affective, and social function impairment in later life; studies of the onset, course, and natural history of mental illness in later life.

Illustrative of the projects in this area is one being carried out by Dr. Leonard Berg of Washington University:

The objectives of this study are to analyze the value of various behavioral and biomedical factors in predicting the development and course of severe senile dementia, and to study the interrelationships of behavioral and biomedical data derived from serial testing of the aged.

Subjects are persons, ages 65 to 75, who exhibit early signs of intellectual decline and controls of similar age, sex, race, and socioeconomic status who are well preserved intellectually. The results of clinical assessment, psychometric tests, the visual evoked response, and computerized tomography are analyzed to determine which measures, either singly or in combination, might be predictive of the severe intellectual decline of senile dementia, or of a much slower decline or stability consistent with what is usually considered normal aging. In addition, the results are compared with the findings at autopsy. The final results of the research are expected to provide information concerning behavioral and physiologic predictors of dementia, behavioral and physiologic changes which predict the progress of the syndrome, as well as indicators of the severity of the disease.

2. Treatment and Delivery of Mental Health Services

Treating mental disorders in later life; coordinating mental health and other services to the aging in the broader health and community services systems; providing services to special populations; structuring of services; and researching new and more effective services.

Illustrative of the projects in this area is one being carried out by Dr. Joseph Barbaccia of the University of California, San Francisco:

Analysis is made of ways in which elderly patients and their families are assisted to prepare for the patients' convalescence and readjustment at home after a period of acute hospitalization. Subjects are 600 geriatric patients treated and discharged from three San Francisco area acute care hospitals, 200 from each hospital. Primarily, diagnoses are arteriosclerotic heart disease and fracture or severe arthritis of the hip. Data are collected on: Ways in which post-hospital services are obtained by elderly patients; the conversion of assessment of need into a service plan; and the effect of the services on mental health and functioning of the patient after discharge. The results of this study are expected to be used as part of inservice training for hospital staff and will form the base of needed laterations in planning for discharge for elderly hospital patients.

3. Program Development, Social Policy, and Social Problems Research in Mental Health and Aging

Institutional program development and alternatives to institutionalization; formal and informal community support systems; financing/reimbursement mechanisms; policy and legal or administrative dimensions in technical assistance and program design; models for research utilization; and models of technical assistance for research development; and studies or developmental life crises, stress, adaptation, and morale in later life with special attention to the prevention of mental disorders.

Illustrative of the projects in this area is one being carried out by Dr. Adrian Ostfeld of Yale University:

The health, psychological, and behavioral effects of severe illness, or death of one spouse upon the other spouse are studied. Three groups of nonhospitalized spouses (categorized as high, intermediate, or low stress according to the severity of the illness of their hospitalized spouse) are followed for 25 months after the death or illness of the hospitalized spouse. Subjects are approximately 1,000 families in which the hospitalized spouse is 56 years of age or older. The relationship between the gradient of stress and the social, psychological, and health characteristics of the nonhospitalized spouses are investigated. Other behavioral and psychological factors by which death or illness in one spouse affects the health and survival of the other are studied. The findings of this research are expected to form the basis of recommendations for clinical interventions with the bereaved. An additional use of the findings is expected to be in curriculum development for mental health professionals.

A list of research grants funded by the Center is included as appendix A of this report. These grants are organized according to the four categories presented. In addition, a fifth category of grants is listed. These grants will be transferred to the administration of the Center in the near future.

B. Research Training

National research service awards, including individual fellowships and institutional awards at the predoctoral or postdoctoral levels, are given to provide support for the training of research scientists in the area of mental health and aging. Research training is just beginning as a Center program. As the research program of the Center gains strength and visibility, however, additional research training programs will likely be initiated.

C. Clinical/Services Training

The Center's program in mental health services manpower development and training focuses on training efforts designed to improve mental health and related services to the aging within both the established mental health service delivery system (e.g., State mental hospitals, community mental health centers, etc.) and the mental health-related support systems (e.g., senior centers, long-term care facilities, etc.). Grants are available in three major categories: Mental health services manpower education/training, mental health services manpower research and demonstration, and faculty development awards in geriatric mental health.

1. Mental Health Services Manpower Education/Training: Short-Term Training Grants

These grants are for the purpose of providing training of a short-term nature and with a view toward upgrading the mental health knowledge and skills of human services and other professional and paraprofessional personnel concerned with aging. Trainees are primarily nonmental health specialists, although mental health specialists may be included where appropriate to facilitate mutual exchange of knowledge, concepts, and practices.

Illustrative of projects in this category is one being carried out in New Mexico to provide short-term training to persons who work in a rural setting with the minority elderly, particularly those of Hispanic descent. The trainees are community service agency workers not traditionally viewed as mental health specialists, but whose work requires skills for dealing with their clients' mental health problems. The course will include segments dealing with general health problems, psychosocial aspects of aging, family problems, mental health of aging, and counseling techniques. There will also be an intensive supervised internship involving field work with community agencies, particularly those serving rural and minority elderly.

2. Mental Health Services Manpower Research and Demonstration Grants

Projects in this category are for the purpose of either generating needed knowledge, curriculum, and technology that can assist in the development of improved education/training approaches and/or demonstrating innovative education/training approaches for professional and paraprofessional personnel in the field of mental health of aging. In order to be eligible for support from the Center, projects must focus on development, testing, refinement, and evaluation of innovative training models that can be of benefit to wide ranges of institutions or services. Priority is given under both research and demonstration grants curriculum and trainer/educator development. These projects are to assess the feasibility of innovative approaches or methodologies prior to incorporating them into ongoing training efforts and to contribute to the "state-of-the-art" of mental health gerontologic/geriatric education and training.

A project which was funded in fiscal year 1980 illustrates this category of grant: The Department of Psychiatry of the University of Texas at Houston was awarded a grant to develop and disseminate model curricula in mental health of the aging which are suitable for introduction into the educational programs of key professional groups serving the elderly population. The professional groups include medicine, nursing, dentistry, occupational therapy, physical therapy, nutrition, social work, chaplaincy, and psychology. These professional areas were selected to provide a multidisciplinary perspective of what is needed in the curricula regarding mental health of aging; also, members of these groups would be the most likely to be in professional contact with the older population.

A list of the clinical training grants funded and administered by the Center in fiscal year 1981 is included in appendix B of this report. Additional applications will be reviewed by the National Advisory Mental Health Council in February and May for funding in fiscal year 1981.

3. Special Projects

Special projects are supported under both of the preceding clinical/services training categories and are for the purpose of supporting conferences, seminars or workshops that promote discussion, sharing of information, and exploration of issues and approaches for addressing training needs in mental health of aging. Topics may include such concerns as identifying special mental health service needs of the elderly and training efforts required to meet them. Projects in this category may also be used to promote dissemination and utilization of important findings from manpower training research and demonstrations in mental health of aging.

4. *Faculty Development Awards in Geriatric Mental Health*

This is a new category of grant which is being implemented in fiscal year 1981. The first applications were submitted on October 1, 1980. The general purpose of the faculty development award is to support, on a pilot basis, the advanced training of an experienced faculty member in psychiatry or psychiatric nursing who will become responsible for the promotion and coordination of the education of the professional schools' students and faculty in geriatric mental health. The objectives of the program are to test the effectiveness of this approach to educator development in mental health of aging and to stimulate an increased awareness of and attention to the mental health needs of the aging within the teaching programs of the professional schools.

D. Nursing Home Improvement Program

For several years, the NIMH has addressed the problems of the quality of long-term care through its nursing home improvement program (NHIP). Following a statement of Presidential support on nursing homes in August 1971, NIMH staff began development of approaches to the creation of short-term training programs in mental health for staff of the Nation's nursing homes. The program was developed through the mechanism of contracts with appropriate educational institutions, professional organizations, and service agencies. This represented the first time that nursing homes per se were made the focus of a specific mental health training program. Because of limited resources, the immediate concern was to develop a program that could have maximum impact in a relatively short period of time, and on as large a segment of the population as possible. At the same time, the program was intended to assure a sound basis on which long-term planning could be built. It was decided that the concern should not be as much with development of training materials or curricula, as with the development of mechanisms for transmitting knowledge of principles and methods of practice which would promote the mental health of patients (and personnel) in nursing homes, and minimize impairment of function caused by mental disorder. For maximum efficiency and impact, it was necessary to call upon existing resources rather than attempt to develop new ones. As a result, the program drew on existing organizations and established "models" of collaboration which could be tested, modified, and then put into operation around the country.

During this past year, the NHIP was assigned to the Center for Studies of the Mental Health of the Aging. This provided an opportunity for closer coordination of research and training activities in mental health of aging with the NHIP and greater participation of NHIP in the Mental Health Systems Act implementation activities. Regional NHIP staff were closely involved in the grant to the American College of Nursing Home Administrators. The ACNHA, in collaboration with the National Council of Community Mental Health Centers, will develop, using a continuing education model, cooperative programs between community mental health centers and nursing homes for the provision of mental health services, case consultation, inservice training of nursing home personnel and program development. This project is national in scope, with training being conducted on a regional basis.

ACCOMPLISHMENTS

A. Cofunding With Other NIMH, PHS, DHHS or Programs Outside DHHS

Not all research in mental health and aging can or should be supported or administered by the Aging Center. In fields with strong and well-established technologies, such as psychopharmacology and epidemiology, specialized expertise already exists in other programs. Similarly, certain research issues are best conceptualized as lifecourse or adulthood issues in which the elderly fit only as part of the study. In these types of circumstances, the Aging Center has established mechanisms for joint funding while still maintaining fiscal control of the funds. Projects have been cofunded with other programs of the Institute, with the National Institute on Aging, the National Institute of Neurological and Communicative Disorders and Stroke, with the Administration on Aging, and with the National Institute of Handicapped Research of the Department of Education. In this way the total aging effort of the Institute is expanded and multiplied.

As with research, not all clinical training in mental health and aging can or should be supported or administered by the Aging Center. In prior years, Center funds have been transferred to the Manpower and Training Division to support aging-related training. In line with recommendations of the President's Commission on Mental Health, aging is among the priority areas toward which 1981 funds will be directed in addition to the funds administered by the Center for short-term training and training/education research and demonstration projects.

B. Technical Assistance

The Center for Studies of the Mental Health of the Aging has conducted a technical assistance project in four DHHS regions during the past 2 years. This project has been supported through 2 percent technical assistance (TA) funds available through the Community Mental Health Centers Act. The projects have been jointly administered by the individual alcohol, drug abuse, and mental health units in the 10 Public Health Service regional offices and the Center on Aging. The focus of the technical assistance is community mental health centers (CMHC's) and the objective is to assist the CMHC's in developing their capabilities to deliver mental health service to the elderly. The Center collaborates with regional office staff in selection, orientation, and evaluation of the technical assistance program.

The technical assistance is provided by consultants, from the project regions, who have demonstrated expertise in program development and geriatric mental health. The consultants work with the CMHC director and the program staff in analyzing needs and available resources and in the development of a program plan specifying goals and objectives for the proposed service.

A total of 39 CMHC's have directely participated, at a total expenditure of $60,000 in the program during the past 2 fiscal years. In fiscal year 1980 two additional regions will participate on this TA project at a proposed cost of $15,000. The total number of target CMHC's is 14. Based on what is learned from these 53, the Aging Center expects to export this knowledge to all 726 CMHC's through publications, workshops, and consultation.

In addition, the Center provides technical assistance through consultation for the development and stimulation of research and training applications focused on the mental health of aging persons. Researchers and directors of training programs are encouraged to contact the Center for discussion of ideas for new research or training projects. Concept papers, preliminary proposals, and later drafts can be submitted for staff review and comment prior to formal submission of the proposal.

Major technical assistance efforts are available to public and private agencies at regional, State, and local levels with the objective of improving programs affecting the mental health of aging persons and especially the delivery of services to aged persons by community mental health centers. For this latter effort, Center staff works with regional offices, States, and individual community mental health centers.

Technical assistance is carried out through consultation, active participation at national, regional, and local meetings and conferences, and development and distribution of publications and other written materials. Particular emphasis is placed on dissemination of information about NIMH-funded research and training projects concerning the mental health of the aged.

As the focal point for activities on mental health of the aging at the National Institute of Mental Health, CSMHA responds to inquiries from professionals and public alike and provides information and referral to other appropriate organizations when indicated.

C. Interagency Collaboration

There are many Federal agencies with programmatic responsibility for dealing with the aged. Consequently, many approaches, both formal and informal, have been established for coordination and joint program development. Examples of these are as follows:

Intergovernmental Science, Engineering, and Technology Advisory Panel. Long-Term Care Task Force. Information and Referral Work Group. Senile dementia initiative. Retirement age of airline pilots. Rural Services Task Force.

Among the many specific examples of collaborative projects, two are especially notable. First, in the area of senile dementia, the NIMH Aging Center, in collaboration with two NIH Institutes (National Institute on Aging and National Institute of Neurological and Communicative Disorders and Stroke), sponsored two international conferences on Alzheimer's disease/senile dementia. These conferences, the first ever held, helped establish the state of the art in research, treatment, services, and policy in this disease. Second, in the area of service delivery, a regional training conference cosponsored by the Administration on Aging and the NIMH was held as the first formal step toward local-level collaboration of aging and mental health services. This approach will be repeated two more times in fiscal year 1981 so as to gain coverage of the entire Nation.

1. Relationships With the National Institute on Aging

The mandate given to the NIMH by the Congress is to conduct a program of research, training, and services for the prevention and treatment of mental illness and for the maintenance and improvement of the mental health of the Nation. Since persons 65 years of age and older now constitute approximately 10 percent of the population and display the highest incidence of new cases of psychopathology, it follows that a significant portion of the NIMH effort should be directed toward the mental health problems and needs of this age group. The basic focus of NIMH efforts must be on mental health. When applied to this age group the essential considerations are the manner in which aging affects mental health and influence of mental health upon aging.

In this context, NIA's interest starts with the aging process itself, whereas NIMH's approach begins from the perspective of the mental health and illness of older people. From another vantage point, while NIA looks at biomedical, social, and behavioral aspects of aging with regard to development, NIMH studies adaptive and aberrant psychosocial functioning of the elderly with attention to etiology, prevention, treatment, and service delivery as they relate to mental disorders in later life. The two institutes also differ in a fundamental structural sense. NIA's focus is restricted to research and research training while NIMH's aging center program encompasses services and clinical training in addition to research and research training efforts.

Since 1974, staff of the NIMH Center for Studies of the Mental Health of the Aging have served on the Interagency Committee on Research in Aging. This Committee, chaired by the Director, NIA, and in conjunction with the National Advisory Council on Aging helped define the research goals of the NIA, and now meets regularly for purposes of coordination and consultation.

In addition, staff of the Center together with NIA staff also serve on the Interdepartment Committee on Aging conducted under the auspices of the AoA, which is advisory to the Commissioner on Aging.

Finally, considerable array of formal and informal relationships exists between the NIMH Center for Studies of the Mental Health of the Aging and the National Institute on Aging. Research applications of interest to both organizations are dually assigned. On occasion, projects with dual assignments, approved by the primary institute but for which sufficient funds are not available, have been transferred to the secondary institute for funding consideration.

D. Publications

Results of research and training projects are usually published in the technical literature of a field by the investigator. In addition, the Center devotes considerable resources to the translation of research findings into materials for practice or training, and to the transmission of this information to interested individuals and groups. Materials for the public and for the stimulation of researchers are also developed by the Center.

Grant No.	P.I.	Title	Totals, fiscal year 1980	Direct costs, fiscal year 1981
	A—Epidemiology:			
[1] 32794	Gurland	Epidemiology of depression in two urban populations	$61, 344	
[1] 32885	Vaillant	Effect of mental health upon aging	49, 107	$36, 000
[1] 33870	Kramer	Epidemiological catchment area	100, 000	100, 000
	B—Clinical:			
33688	Prinz	Sleep/waking patterns in dementia	123, 095	90, 332
30664	Niederehe	Memory impairment in affective disorders of aged	51, 022	
31054	Berg	Mental health in the aged: Biomedical factors	11, 500	
32740	Feinberg	Personality, sleep and MH in the aged	81, 475	6, 900
32668	Larson	Dementia and MH in the aged	63, 123	53, 700
31054	Berg	Mental health in the aged: Biomedical factors	160, 895	137, 000
32612	Hardt	Anx. and aging-intervention with EEG alpha feedback	88, 117	65, 766
33704	Palmore	Mental illness and soc. support amg. very old	184, 720	115, 000
32172	Riege	Nonverbal memory in aged mentally healthy or ill	35, 322	
32577	Ferris	Neurometric assessment of MH in aging	209, 498	129, 923
32750	Jacobs	Psychosocial and endocrine aspects of grief in men	122, 593	68, 263
33181	Vrtunski	Psychomotor slowing and age: Microbehavioral analysis	32, 320	27, 309
33282	Kripke	Home sleep diagnosis for the aged	24, 108	
27281	Nathan	Aging: Brain structure and sociobehavioral variables	167, 204	111, 727
29535	Persky	Sexual adjustment and aging	115, 467	
30626	Yamamura	Neuropsychiatric disorders: Transmitters and receptors	82, 725	59, 745
34889	Haug	Depression in elderly: Causes, consequences, care	19, 066	
28460	Weitzman	Psychoneuroendocrine rhythms, and sleep disorders	149, 614	125, 000
	C—Treatment:			
[1] 28393	Granick	Improving congitive and adaptive abilities of aged	82, 806	
33677	Jarvik	Psychotherapy in geriatric depression	72, 005	58, 850
[1] 30099	Alexander	Corticosteroid effects on learning and memory	7, 250	
[1] 33699	Cole	Lecithin in senile dementia	65, 000	
[1] 29819	Melinger	Natl. trends in psychotherapeutic drug use	51, 745	
[1] 34223	Shader	Clin. applications of pharmacokinetics in psychiat	95, 805	
[1] 31357	Jarvik	Drug treatment of depressed outpatients	118, 285	33, 000
[1] 29590	Ferris	Psychopharm of neurotransmitter systems in aging	31, 000	31, 000
[1] 32724	Corkin	Lecithin precursor treatment in Alzheimer's dis		70, 276
[1] 34042	McNair	Tricyclic antidepressants and congitive toxicity	53, 000	13, 902
	D—Services:			
27361	Brody	Mental & physical health practices of older people	143, 736	
25373	Cohen	Family agency team for noninstitutional care of aged	163, 871	
34426	Koh	Adaptive capabilities of newly immigrated Asian elderly	94, 654	62, 334
32731	Barbaccia	Adjustment of older persons after acute hospitalization	205, 162	150, 038
	E—Psychosocial:			
32668	Carp	Testing a congruence model of aging and MH	122, 852	20, 000
35312	Lawton	Old and alone: Gender, marital status and MH	148, 485	120, 075
31095	Scheidt	MH and environmental adaptation of rural elderly	139, 951	99, 978
35360	Poulshock	Care for elders and MH of family members	123, 357	100, 000
34334	Kiefer	MH of Korean-American elderly	48, 594	36, 789
29687	Kahana	Voluntary relocation and MH of the aged	58, 086	
33645	Masuda	MH of aging Japanese-Americans	89, 164	67, 230
31907	Johnson	Interdependence and aging in ethnic families	69, 493	
33779	Becker	Stress vulnerability in Alzheimer patients' families	101, 256	76, 259
32155	Kivnick	Grandparenthood—meaning and mental health	5, 767	
34098	Pearce	Skills for interpreting and coping with retirement	15, 660	
27894	Faulkner	Maintenance and change of MH of poor, urban, black elderly.	175, 295	
35252	Brody	Women, work and care of the aged—MH effects	131, 867	138, 000
26121	Atchley	Impact of retirement on aging and adaptation	48, 967	54, 568
31743	Cohen	Networks of the aging living in midtown SRO hotels	52, 569	
32652	Kroeger	Retired women—career commitment and MH	170, 711	110, 342
32999	Ward	Aged residential segregation: MH impact	150, 732	
29657	Nydegger	Timing of fatherhood: Adult child's perspective	95, 455	102, 559
32260	Ostfeld	Effect of spousal illness and death in older families	280, 668	149, 948
33141	Lee	Fear of victimization among the elderly	46, 320	28, 659
32305	Chiraboga	Mental illness and divorce: A lifespan study	37, 000	
33713	Fiske	MH—a longitudinal study of adaptation	67, 031	67, 000
	RA	Administration on Aging (mini-White House conference).	9, 500	
	RA	Natl. Inst. for Handicapped Rsch	50 000	100, 000
	RA	Administration on Aging—(housing)		20, 000
	RA	Heart, lung, and blood		210, 000

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[1] Cofunded.

CLINICAL/SERVICES TRAINING GRANTS FUNDED BY CSMHA

Grant Number	Program director-institution	Title	Award[1]		
			Fiscal year 1980	Fiscal year 1981	Fiscal year 1982
5-T01 MH15538-03	Kahana, Boaz, Wayne State University.	Interdisc. trng. program in MH and aging.	$75,000	$75,000	$75,000
5 T41 MH15716-02[2]	Santos, John, Notre Dame	Outreach trng. to assist rural and minority elderly (N. Mexico).	58,665	89,519	56,919
5 T15 MH15686-02[2]	Hands, Donald, Pittsburgh Pastoral Institute.	Clergy for the aged	21,764	22,930	
5 T31 MH15696-02[2]	Gaitz, Charles, TRIMS, Houston, Tex.	Trng. in geriatric phychiatry and psychology.	168,000	176,404	
5 T15 MH15711-02[2]	Scott, Judith, Gay Community Service, Minn.	Aging and the affectional preference minority.	35,250	38,301	
5 T15 MH15544-03	Gottesman, Leonard, Temple University.	Gerontology for MH educators and adm.	136,432		
5 T15 MH14947-03	Eastman, Pauline, Lakeshore MH Institute, Tenn.	Aging, NH and cont. ed	54,581		
5 T15 MH14785-03	Connelly, Richard, University of Utah.	Focus on MH aging	75,008		
5 T24 MH15438-03	Waters, Elinor, Oakland University, Mich.	Counseling and gerontology for aging services providers.	96,791		
5 T21 MH14435-05	Edinberg, Mark A., University Bridgeport, Conn.	Programs on aging/gerontology interdisciplinary.	34,636		
1 T01 MH16133-01[2]	Levenson, Alvin, University Texas, Houston.	Model curricula in MH of aged.	56,315	98,866	50,026
1 T15 MH16237-01[2]	Cyr, Bruce A. ACNHA/Washington.	New model training for CMHC Nursing home staff.	52,762	49,901	

[1] Direct costs only.

[2] Reviewed and approved by aging panel—all others transferred to CSMHA from Division of Manpower and Training, NIMH.

NATIONAL INSTITUTE ON ALCOHOL ABUSE AND ALCOHOLISM

INTRODUCTION

Alcoholism is a serious health problem among the elderly. A recent NIAAA report, "Alcohol and Health," indicates that a significant number of people 60 years old and over have problems with alcohol. Loneliness, loss of spouse, physical or emotional separation from children, ill health, or lack of purposeful employment can precipitate alcohol problems in the elderly. Estimates of the number of elderly alcoholics range from 1 to 2.7 million.

An analysis of national surveys on alcoholism among the elderly indicates that the significance of this problem has only recently been appreciated. The majority of the problem drinkers aged 65 and over are unidentified, overlooked, and untreated. It has been estimated that about 85 percent of all elderly problem drinkers are not receiving any type of service related to their alcohol problems. One of the major barriers to treatment of alcoholic senior citizens is the failure to consider alcoholism as a possible diagnosis. What is perceived as frailty, senility, or simply the unsteadiness of old age may in fact be alcoholism. Relatives, friends, and service professionals working with the elderly may be reluctant to acknowledge the need for alcoholism treatment. In addition, social agencies for the aged usually are poorly equipped to treat alcoholic problems, and many alcohol treatment centers are geared to a younger clientele.

Restricted medicare coverage is an additional stumbling block to the treatment of alcohol-related problems among the elderly. Almost all of the elderly depend to some extent on medicare to pay for health services. Medicare is, however, a health insurance program designed to pay for inpatient care and physician services. Most of the nonphysician health and social services that are a part of comprehensive alcohol treatment programs are not covered by medicare.

NIAAA has a legislative mandate to encourage and give special consideration to the submission of project grants and contracts for the prevention and treatment of alcohol abuse and alcoholism among the elderly under section II of Public Law 96-180. In response to the recognized needs of the elderly and the legislative mandate, NIAAA has initiated a number of special activities targeted to this population, which are described in the following narrative.

INTERAGENCY ACTIVITIES

NIAAA, in cooperation with the Health Care Financing Administration, has undertaken a major demonstration program to improve medicare and medicaid coverage for alcoholism treatment services. NIAAA will provide up to $1 million in fiscal year 1981 to fund demonstration grants for the purpose of demonstrating the feasibility and effectiveness of providing alcoholism treatment services in free-standing residential and outpatient settings, which are less expensive than the inpatient services currently covered by medicare and medicaid.

Other interagency activities initiated in fiscal year 1981 include:

—Participation in the White House Conference on Aging to highlight the alcohol-related problems of the elderly and to stimulate social concern in this area.

—Participation on the National Council on Alcoholism Blue Ribbon Committee on Aging and Alcohol.

—Dialog with the Administration on Aging to explore cooperative activities.

TREATMENT

The elderly are receiving alcoholism treatment services throughout the country through most of the programs currently funded by NIAAA, with the exception of programs specifically designed for youth. These programs offer such services as outreach, referral, counseling, detoxification, and other forms of treatment on an inpatient, outpatient, or day care basis.

In addition, NIAAA presently funds two programs specifically designed to meet the needs of the elderly who are experiencing difficulties with alcoholism or other alcohol-related problems. NIAAA provides approximately $500,000 per year for these two programs. The programs are located in Vancouver, Wash. and New York City.

The Vancouver senior alcohol services project is administered by the Health and Welfare Planning Council of Clark County, Wash. The program is targeted for both men and women 60 years of age or older who live in Clark County and who have a problem with their use of alcohol. The program is also available to provide services to relatives or friends of the drinking person who are concerned with and/or affected by that person's misuse of alcohol. The program meets needs beyond alcohol treatment in such areas as nutrition, health, transportation, and other daily living activities. The program provides training in alcoholism and gerontology and evaluates the treatment and training efforts. In addition, research is being conducted on the drinking patterns of both alcoholic and nonalcoholic elderly persons.

The Bronx older American problem drinker driver project is administered by the Neighborhood Engaged Service Center, Inc. The target population for the program are the elderly residents of the Bronx, New York City, who exhibit symptoms of problem drinking. The program consists of day care facilities developed to insure that the elderly problem drinker receives a comprehensive array of direct physical and social services, including outreach, evaluation, referral, individual and group counseling, crisis intervention, alcohol education family counseling, recreational therapy, client advocacy, transportation, hot lunches, and coordination of services with other social agencies.

During fiscal year 1981, the training branch will continue to stimulate applications and provide technical assistance to potential applicants for grants to provide training to serve the needs of elderly alcoholics.

Through its contractor, the National Center for Alcohol Education, NIAAA will develop prevention education materials for the elderly in fiscal year 1981 The materials will be developed in a handbook format with a companion curriculum guide. They will contain information about the effects of alcohol on the body, psychologically and physiologically; the influence of the aging process on consumption, the impact of changes in lifestyle on customary drinking behavior;

for example, retirement, change of geographic area, and loss of companionship. These materials will be targeted to staff of residences for the elderly, senior neighborhood centers, and nursing homes. This project will be coordinated with *Elder Ed*, an audiovisual training program developed by the National Institute on Drug Abuse, which presents material on the use of alcohol with prescription drugs.

In response to NIAAA's technical assistance efforts to encourage applications for programs to specifically serve the aging, four grant applications were received in fiscal year 1980. Only two of these were recommended for approval by the National Advisory Council.

In fiscal year 1981, NIAAA plans to develop a special announcement to encourage and stimulate grant applications to provide alcoholism treatment services specifically for the aging. Technical assistance will be provided to State alcoholism authorities and potential applicants to help insure quality grant applications.

RESEARCH

During fiscal year 1980, the NIAAA Division of Extramural Research funded a pilot study in Los Angeles, Calif., to investigate alcohol drinking practices among the aging. The pilot survey study will investigate the alcohol drinking practices in a sample of elderly community residents in Los Angeles County. Status changes which may be related to drinking patterns in this population will be examined in six life areas: Work, family, social networks, economics, age, and health. Social and psychological correlates of drinking patterns will also be assessed. These include life satisfaction, personal control of mastery, and tendencies to "give up" in dealing with problems.

During fiscal year 1981, the NIAAA Division of Extramural Research is planning to hold a workshop on "Alcohol Abuse Among the Aging," in collaboration with the National Institute on Aging. The workshop will enable investigators who are concerned with alcohol-related problems of the elderly to exchange information, serve as a forum for evaluation of ongoing research and provide future research directions. The proceedings and recommendations of the workshop will be published in the NIAAA Alcohol Research Monograph Series.

TRAINING

During fiscal year 1980, the NIAAA Training Branch funded two training programs for approximately $260,000 to train alcoholism service providers for the elderly.

One grant was awarded to the Mental Health Institute of Independence, Iowa to improve the quality of service available to the elderly population who have problems with alcohol. The program will provide training for health and social welfare personnel, and attempt to develop a training model for use by other programs. Specialized training in the alcohol problems of the elderly will be offered to such service providers as policemen, firemen, AA members, volunteer workers, health and social welfare personnel, and alcohol counselors.

The second grant was awarded to the School of Social Work of Adelphi University in Garden City, N.Y. The purpose of the grant is to train social work students in serving alcoholics residing in single room occupancy hotels located in the Upper West Side of Manhattan, N.Y. This project will put special emphasis on developing training approaches for intervention with the aging and aged alcoholics.

NATIONAL INSTITUTE ON DRUG ABUSE

INTRODUCTION

NIDA and its predecessor agencies were formed to address public health problems created by illicit drug use—particularly heroin use. In response, NIDA developed a nationwide treatment services network.

Illicit drug use/abuse has traditionally been most severe among adolescents and young adults. Consequently, the bulk of NIDA's efforts and resources have not been allocated for services to the aging. The number of people in NIDA-funded treatment programs who can be defined as elderly is small. However, NIDA has supported projects focusing on the elderly in the areas of research, public information, and training. NIDA estimates its combined expenditures on the elderly in fiscal year 1980 at approximately $3,602,300.

RESEARCH

During the past year, NIDA initiated a thorough computer search to identify all grants and contracts which include a focus on the elderly. NIDA identified virtually all the published literature concerning drugs and the elderly. On July 14, 1980, the Psychosocial Branch of NIDA's Division of Research sponsored a technical review entitled "Research Issues in the Study of the Drug Abuse Among the Elderly." Presentations were made by noted experts in the fields of gerontology and drug abuse, and these experts, together with the invited guests, discussed relevant research issues, and outlined a study to be conducted.

The elderly are at high risk for drug misuse and abuse because they generally face increased stress and decreased personal and social resources for coping. In addition, the elderly consume large numbers and quantities of drugs, prescription and nonprescription combined. In a recent NIDA-sponsored study, for example, David Guttman (1978), the Catholic University of America, found that 62 percent of his Washington, D.C., sample used prescription drugs and that more than one-third used between two and four prescription drugs; 69 percent used over-the-counter drugs; and 44 percent used alcohol at least several times a month. Approximately 14 percent of the prescribed drugs were for sedatives and/or tranquilizers and more than one-third of the respondents used an internal analgesic. Approximately half of the respondents used some type of combination of legal drugs and over-the-counter drugs in combination with alcohol. Other studies have reported that the hoarding and sharing of drugs among the elderly is not an uncommon occurrence.

NIDA has also produced the following publications as the result of recent grants, contracts, or conferences: (1) "The Aging Process and Psychoactive Drug Use"; (2) "A Study of Legal Drug Use by Older Americans"; (3) "A Survey of Drug Taking Behavior of the Elderly"; and (4) "Drug Abuse and the Elderly: Perspectives and Issues." The Services Research Branch is currently supporting one elderly project—a survey of drug use patterns and related behaviors—of a representative sample of the elderly in Houston, Tex.

PUBLIC INFORMATION

The elder-ed program consists of 30-minute films and booklets designed to assist the elderly to be fully aware of the benefits and risks of medicine and prescription drugs. Elder-ed is a program on wise use of prescription drugs and how to communicate effectively with health care practitioners. Two booklets make up the elder-ed publications kit. "Using your Medicine Wisely: A Guide for the Elderly" is a discussion of sensible precautions about taking medicines. "Passport to Good Health Care" is an 8-page, passport-size booklet which has space to write down medical emergency information as well as complete descriptions of all the medicines and prescription drugs the senior citizen takes.

TRAINING

During the past year, NIDA has reproduced and distributed two manuals, one aimed at providing instructions for service providers, entitled "Drug Misuse and Abuse Among the Elderly," originally published by the Door of Central Florida, Inc. The training package's basic objective is to improve service providers' understanding of the physical, psychological, and social problems of aging that may contribute to drug misuse and abuse by the elderly. The second training manual for pharmacists and pharmacy students, "Improving Use of Drugs by Elderly Patients," a learner's manual, was originally published by the Florida Drug Abuse Prevention and Education Trust in Operation PAR, Inc. This manual provides information and reference sources for pharmacists who provide medication to ambulatory elderly patients.

TREATMENT

The new "Statewide Services Grant Guidelines" require States to assess the need for drug abuse treatment services among the elderly and to put forward objectives for meeting those needs. Similarly, the "State Plan Guidelines" for implementation of section 409 now require that the plan address the needs of the elderly.

INTERAGENCY ACTIVITY

In addition to maintaining close contact with NIMH and NIAAA efforts related to the elderly, NIDA also exchanges information with officials from the Administration on Aging (AoA) and National Institute on Aging (NIA) regarding their ongoing efforts. Further, NIDA is represented on the planning committee for the 1981 White House Conference on Aging.

FOOD AND DRUG ADMINISTRATION

Laws enforced by the Food and Drug Administration (FDA) are designed to protect the health, safety, and pocketbooks of all consumers regardless of age. This protection, however, is particularly important to the elderly consumer, and many of FDA's actions are of special interest to this age group.

PATIENT PACKAGE INSERTS

In September, 1980, the Food and Drug Administration initiated a pilot patient package insert project which requires that pharmacies give patients easy-to-read information along with certain prescription drugs. The "patient package inserts" (PPI's) will describe what the drug is for, what side effects may occur and how to take the drug properly to get the most benefit. The leaflets will be produced by drug manufacturers and will also be available to hospitals and nursing homes. The leaflets, covering 10 drugs or classes of drugs, should be available in pharmacies beginning in mid-1981. Their benefits to the public and their cost will be evaluated over the next 3 years. Then, a decision will be made whether to require patient package inserts for other prescription drugs.

Patient package inserts already are required by FDA for some prescription drugs such as birth control pills and estrogens for menopausal use and a few manufacturers are voluntarily distributing patient information leaflets for other drugs.

The 10 drugs or categories of drugs for which patient package inserts will be required are: *Ampicillins*—a class of penicillin-type antibiotics; *benzodiazepines*—a class of minor tranquillizers, including Valium (chlordiazepoxide), Librium (diazepam) and Tranxene (clorazepate dipotassium); *cimetidine*—used for the treatment of ulcers; *clofibrate*—used to treat elevated fats in the blood; *digoxin*—for use in treating heart problems; *methoxsalen*—used in the treatment of skin pigmentation problems and, as an investigational drug, in psoriasis; *thiazides*—a class of diuretic drugs commonly used in the treatment of high blood pressure; *phenytoin*—a drug used to control epiliptic seizures; *propoxyphene*—a pain reliever, and *Bendectin*—a drug used to prevent nausea in pregnancy. (Bendectin replaced Warfarin as one of the drugs for which PPI's were originally proposed.)

In selecting these drugs, FDA considered whether:

—Precise use of the drug is essential to achieving its therapeutic effect.

—The drug is widely prescribed and used.

—The drug has the potential to cause significant adverse effects.

—There are likely to be severe problems if patients do not follow the dosage schedule and directions for use; and

—The use of the drug is largely a matter of personal choice by the patient (such as birth control pills or minor tranquilizers).

FDA believes that the need for such a program is clear. Patients who use prescription drugs improperly may not receive the intended therapeutic benefit and as a result prolong the need for medical care. They may stay sick longer, losing additional days of work, or they may suffer adverse reactions, requiring hospitalization. Since the elderly consume disproportionate share of medication they should benefit from the PPI program more than the general population.

FDA published draft guidelines for 10 patient package inserts in the September 12, 1980, Federal Register. FDA has published guidelines for three drug categories (Cimetidine, Clofibrate, and Propoxyphene) in final form on November 21, 1980. Bendectin replaced Warfarin on the list on December 1980. Three additional final guidelines will be published in December, and the final four in January. Pharmacists will have 6 months after publication of the final guidelines to begin distributing the patient package insert which will be printed by the manufacturers of the drugs. During the 3-year evaluation period, FDA will permit the testing of alternative methods of distributing written information to consumers.

The policy on patient package inserts was proposed by FDA on July 6, 1979, with an opportunity for public comment. Hearings were held throughout the country to learn from manufacturers, health professionals, and consumers their views. FDA received and analyzed 1,500 written comments on the proposal.

OTC (OVER-THE-COUNTER) MONOGRAPH REVIEW

OTC drug monographs establish standards for specific classes of over-the-counter drug products to insure a specific level of quality among products of a given type. This standard permits the consumer to purchase the least expensive brand in safety. This is especially beneficial to the elderly. Most of them are on fixed incomes ,and they often use a great deal of medication.

FDA hopes to publish the tentative final monograph for analgesic in November 1981. The proposal was published in July 1977. The panel phase for laxatives was completed in 1975 and the tentative final monograph is scheduled for publication in September 1981. Nighttime sleep aids had their panel report published in December 1975, the tentative final monograph was published in June 1978, and the final monograph will be published in December 1981. The panel for digestive aid preparations adopted its report in January 1979 and hopes to publish the proposal in April 1981. The proposal for external analgesics was published in December 1979 and the tentative final monograph is scheduled for completion in April 1983. The proposed monograph for vitamins and minerals was published in March 1979, and it is hoped that the tentative final monograph will be published in July 1982.

DRUG EXPERIMENTATION IN ELDERLY

In the past, comparatively little clinical research has been performed upon the elderly. However, when it is performed the question of informed consent sometimes becomes an issue, and guidelines are being finalized which will establish parameters under which the institutional review boards must determine whether specific groups who may not be able to protect their own rights such as children, the elderly, and prisoners, are receiving adequate protection. These boards are appointed by the Agency to monitor research conducted in the development of new drug applications.

DESI DRUGS (DRUG EFFICACY STUDY IMPLEMENTATION)

During fiscal year 1980, the Bureau of Drugs removed 26 ineffective general products (those having new drug applications) and 405 specific drug products (abbreviated new drug applications) and approved 151 specific drug products. This program will help assure that consumers purchase only those drug products which will effectively treat the conditions for which they are indicated. Since the elderly use a disproportionately high percentage of drugs, this program should benefit them more than it does the general population.

THE MAXIMUM ALLOWABLE COST (MAC) PROGRAM

FDA is assisting in the Departmentwide MAC program which is aimed at reducing health care costs through the increased use of lower cost generic drugs which are determined to be medically equivalent. FDA develops lists of generic drug products which are medically equivalent to brand name products.

The MAC program is conducted to prevent medicare and medicaid (tax-supported programs) from paying premium prices for brand name drugs when lower cost, medically equivalent generic versions are available. The MAC program adopts those products on FDA's generic drug list which meet their requirements. The elderly are benefited by paying lower costs for their needed medication.

MEDICAL X-RAY GUIDANCE AND EDUCATION EFFORTS STEPPED UP

Of the approximately 270 million medical X-ray examinations conducted in the United States annually, a substantial proportion are performed on elderly patients. It is generally acknowledged that a significant number of X-ray procedures may not be medically needed; factors which contribute to X-ray overuse the testing of alternative methods of distributing written information to part of physicians, and a lack of clear-cut criteria as to when certain X-ray procedures are indicated and when they are not.

FDA is seeking to address these problems with two new programs, one addressed to physicians and the other to patients. To provide better guidance for physicians on the indications for certain X-ray examinations, the Agency is convening expert panels of physicians to develop what it calls "X-ray referral criteria"—recommendations on which signs, symptoms and/or patient history warrant the use of X-rays in a particular clinical circumstance. As they are developed, these recommendations will be widely publicized to the medical community through professional journals, editorials, etc.

In a parallel program to educate consumers about medical X-rays, FDA has launched a nationwide public information campaign that, among other things, cautions consumers not to insist on X-rays, advises that they discuss with their doctors the need for an X-ray examination if one is being considered, and that they keep a record of previous examinations in an effort to avoid needless "repeats."

FRAUDULENT AND QUACK DEVICES

The Bureau of Medical Devices briefed an investigative team of the House Select Subcommittee on Aging about the Bureau's activities to protect elderly consumers against fraudulent medical devices, particularly those associated with arthritis. The investigative team was trying to gather evidence to request hearings on the special medical problems faced by the elderly. The Bureau explained its policies on fraudulent devices: the guidelines followed by field investigators for detecting and taking action against deceptive devices; the consumer education program implemented by FDA's Consumer Affairs Offices; and FDA's collaborative efforts with the U.S. Postal Service and the Federal Trade Commission to regulate deceptive devices. The team was shown samples of fraudulent devices and deceptive advertisements.

The FDA's quackery education program has been directed at generating local and national interest in recognizing medical and health frauds. The FDA prepared a series on device quackery for local television. The television spots discuss and describe various types of device quackery and medical fraud. The series, available through local Consumer Affairs Offices, illustrates examples of devices that make false and misleading claims. These examples include arthritis and pain relievers, figure enhancers, sex aids, hair growth and removal devices, and weight reducing devices.

FDA developed and is distributing a booklet entitled, "The Big Quack Attack: Medical Devices." The booklet contains information on device fraud and informs consumers of the steps they should take to protect themselves from device quackery. Included in the booklet are the names of devices and device manufacturers that the FDA or the U.S. Postal Service have acted against for false and misleading claims in their respective labeling and advertisements.

TESTING NONDIRECTIONAL HEARING AIDS

A program of testing nondirectional, behind the ear hearing aids for compliance with the Federal standard prescribed under 21 CFR 801.420 was completed. Samples from eight of the firms met all major requirements, although three of these firms or samples had minor labeling problems. Of the remaining samples, 12 failed in some way to perform according to specifications contained in the user instructional brochure and/or other analysis of labeling. Four other firm's samples revealed problems serious enough to require followup GMP inspections. FDA issued letters to the remaining firms enumerating minor device deficiencies.

INTRAOCULAR LENS INVESTIGATION

The Ophthalmic Device Section, an extra-Agency advisory group of the Ophthalmic, Ear, Nose, and Throat and Dental Devices Panel conducted public hearings on January 7 and February 12, 1980, reviewing testing of intraocular lenses (IOL's) in humans as part of the safety of ongoing IOL clinical investigation. IOL firms have investigations that track over 100,000 lens implantations per year. These investigations started in 1978 and are projected to run until 1981.

The advisory group submitted a report to FDA on March 7, 1980, which in part, recommended that:

(1) An ongoing biostatistical review of the study be continued to identify and correct any possible study-design deficiencies.

(2) A revised updated patient consent form be drafted for use in the study.

(3) Blue Cross-Blue Shield and medicare data on contract surgery and IOL implantation be compiled as auxiliary investigative data.

(4) FDA expand its informational activities to provide the public with more information on the progress of the IOL clinical investigation.

SODIUM AND POTASSIUM LABELING

FDA will publish, in early 1981, a proposal that will require sodium and potassium labeling and establish definitions for "low," "moderately low," and "reduced" sodium. This issue was addressed in FDA's 1979 Federal Register proposal on food labeling. The document is presently being reviewed within FDA.

CHOLESTEROL CONTENT LABELING

FDA is proposing that cholesterol and fatty acid content of food be included as part of the nutrition labeling when claims on these substances are made. It defines the terms: "cholesterol free," "low cholesterol," and "reduced cholesterol." FDA expects to publish this proposal in the Federal Register in late December 1980.

TOTAL DIET STUDIES

FDA is studying the possibility of modifying its market basket surveys of chemical contaminants and trace nutrients in the total diet, by basing it on dietary consumption data from the U.S. Department of Agriculture (USDA) and Health and Nutrition Examination Survey (HANES), Department of Health and Human Services. The current studies are based on dietary consumption data developed by USDA in 1965. Foods that are representative of a total diet are grouped in 12 categories (e.g., leafy vegetables; meat, fish, and poultry; etc.). These foods are collected and prepared as if in a typical kitchen. FDA then analyzes them for trace nutrients and for chemical contaminants. Presently, FDA is studying the diet of teenage males, 6-month-old infants, and 2-year-old children. By having more flexibility in developing data on levels of nutrients and contaminants, FDA will be able to estimate various food intakes for different age groups, including the aged. While FDA does not expect to begin work on this until fiscal year 1983, it is developing plans on how this will be accomplished.

COLOR ADDITIVES

Lead Acetate. On October 31, 1980, FDA published a final rule in the Federal Register to permit use of lead acetate as a color additive in cosmetics that color hair on the scalp. Lead acetate is an ingredient in some dyes that progressively darkens hair (e.g., Grecian Formula). FDA had conducted tests to determine whether a significant amount of lead acetate is absorbed through the skin when used as a hair dye. FDA found that the amount of lead absorbed from the use of such dyes is minuscule compared to total human exposure to lead. FDA is requiring, however, that all hair dyes containing lead acetate bear this statement:

"CAUTION: Contains Lead Acetate. For external use only. Keep this product out of children's reach. Do not use on cut or abraded scalp. If skin irritation develops, discontinue use. Do not use to color mustaches, eyelashes, eyebrows, or hair on parts of the body other than the scalp. Do not get in eyes. Follow instructions carefully and wash hands thoroughly after each use."

FOOD LABELING

In refining its food labeling strategy as a result of the 1978 food labeling hearings and the 1979 consumer food labeling survey, FDA is proposing several specific labeling regulations that pertain to:

—Declaration of all optional ingredients in standardized foods.

—Definitions of "low cholesterol," "reduced cholesterol," and "cholesterol-free."

—Specific fat source declaration if over 10 percent of dry weight.

—Quantitative declaration of sodium, potassium, and total sugars as part of nutrition labeling.

On July 8, 1980, FDA announced its plans for the development of alternative label formats. FDA awarded a contract to Robert P. Cersin Associates, Inc., for the development of new labeling formats. A series of public meetings will be held to provide direct input to the contractor effort. The first public meeting was held in Washington, D.C., on October 6, 1980. The contractor will present alternative formats for further study by early 1981.

HEALTH RESOURCES ADMINISTRATION

PROGRAMS THAT IMPACT ON THE ELDERLY

HEALTH PLANNING

The health planning program is aimed at developing a two-tiered structure of State and local health planning agencies which are responsible for carrying out a range of planning, regulatory, and resource development functions. This network is designed to deal with the problems of access to, and the cost and quality of, health services.

In doing so, the health systems agencies (HSA's) and the State health planning and development agencies (SHPDA's) address a broad range of health care system issues such as reimbursement methods, regionalization of services, maldistribution of manpower and other resources, "competition" versus "regulation," and capital investments for health facilities.

A study currently underway indicates that planning agencies continue to place a high priority in their plans and implementation activities on long-term care, particularly in the areas of SNF/ICF beds and home health care. 75 percent of the agencies studied have developed goals and objectives for SNF/ICF beds and/or home health care. While the review of specific project applications remains one of the primary means of implementing goals and objectives for long-term care, agencies are increasingly developing other approaches which rely more heavily on the involvement of consumers and coalitions of providers, government agencies, and interest groups. For example:

—The HSA of Southeastern Pennsylvania (Philadelphia) is participating with a coalition of providers and consumer groups in a Robert Wood Johnson Foundation demonstration grant to develop and improve the delivery of noninstitutional long-term care services. The HSA has also received a grant from the Administration on Aging to coordinate the HSA's planning with that of the five agencies for the aging which serve the area.

—Working with local community groups the Florida Gulf HSA (St. Petersburg) has promoted the concept of share homes for the elderly as an alternative to institutionalization and has helped develop the Suncoast Gerontology Center which will serve as a resource for studying and seeking solutions to the problems of the elderly in the area.

Both HSA's and SHPDA's have continued to emphasize the appropriate distribution of long-term care beds through a variety of approaches including adding new beds, decreasing beds in areas where beds exceed the need, and conversion of beds—both conversion of other types of beds (primarily acute care) to SNF/ICF beds as well as conversion of SNF/ICF beds to other uses.

To accomplish this, agencies are developing more refined methods for estimating bed needs and more precise standards and criteria for determining how to allocate beds. For example:

—The Massachusetts SHPDA through a comprehensive process involving HSA's and provider groups has developed a set of specific standards and criteria for various types of services and beds. The SHPDA is using these standards and criteria to reallocate long-term care beds from areas of low need to areas of high need.

—Faced with a situation where it was difficult to accurately determine SNF/ICF bed needs on an HSA-wide basis because of the migration of patients across county boundaries the Philadelphia HSA has developed and implemented an innovative technique for estimating the need for and allocating beds on a small geographic area basis (i.e., service areas below the county level).

The Bureau of Health Planning, recognizing the priority placed on the development of home health services by planning agencies, has distributed to the agencies a technical assistance manual "Planning for Home Health Services" which provides basic information on the planning and development of home health care as well as references for sources of additional technical assistance.

BUREAU OF HEALTH PROFESSIONS

Fiscal year 1980 program efforts directed toward the development of human resources needed to provide health care to the aged are summarized below for the four program divisions of the Bureau.

DIVISION OF ASSOCIATED HEALTH PROFESSIONS

Medical and other health professions schools received 13 grants totaling approximately $1.5 million to continue projects designed to improve the knowledge, skills, and practices of health professionals in assessing nutrition status in health and disease and advising and instructing patients about diet and nutrition. The grant program impacts on all types of patients, including the aged, and emphasizes interdisciplinary team training which must include medical students and at least two other professions which typically are dietitians/nutritionists, nurse/nurse practitioners, and physician assistants.

Thirteen grants, totaling approximately $923,000, were also awarded to medical and other health professions schools to train and motivate health professions students to provide health services in a more effective manner through improvement of the affective relationships between health practitioners and patients. The program focuses on the roles of practitioners in the improvement of personal interactions, the provision of necessary and desired psychosocial support, and the motivation of behaviors that ameliorate illness and promote health. These factors are especially important in service to the aging. Programs that included hospices as a setting were given funding preferences.

Allied health special project grants which received continued support were: (1) University of Northern Colorado for training in geriatric aural rehabilitation ($35,191; prior 4 years—$265,684); (2) Quinnipiac College (Hamden, Conn.) for coordinated education leading to licensure in long-term care administration ($48,835; prior 4 years—$197,084); (3) State University of New York at Stony Brook for gerontology curriculum development to train students in the School of Allied Health Professions at both the undergraduate and graduate levels ($17,707; prior 4 years—$134,172); and (4) University of Texas for gerontology services administration program at the certificate and baccalaureate level ($19,714; prior 2 years—$111,986). Yale University was awarded $30,240 for the last year of a 3-year public health special project grant for long-term care planning, evaluation, and policy analysis. Another award ($58,789) went to George Washington University for the first of a 3-year project for a long-term care administration program.

A contract effort ($126,341) was completed with the Association of Schools and Colleges of Optometry for the development of a curriculum plan in rehabilitative optometry. The plan identified those specialized skills necessary to treat moderately severe to severe visual impairments primarily seen in the elderly.

DIVISION OF NURSING

Special emphasis was given in the Nurse Training Act of 1975 to the problems and health care of the aging. Grants and contracts were authorized for special projects to improve curricula in schools of nursing for geriatric courses and to assist in meeting the costs of developing short-term inservice training programs for nurses' aides and nursing home orderlies. The latter programs emphasized the special problems of geriatric patients and included training for monitoring the well-being, feeding and cleaning of nursing home patients, emergency procedures, drug properties and interactions, and fire safety techniques.

Under section 822 of the Public Health Service Act (PHS Act) nurse practitioner grants and contracts were authorized in fiscal year 1980 to educate nurses in the provision of primary health care to the elderly. The following active projects provide nurse practitioner training support in primary care for geriatric patients.

Applicant	Title	Fiscal year 1980 support
University of Pittsburgh, Pittsburgh, Pa	Adult, family, geriatric nurse practitioner (certificate program).	$169,242
State University of N.Y., Upstate Medical Center, Syracuse, N.Y.	Adult, family, geriatric nurse practitioner (certificate program).	180,495
University of California, Davis, Calif	An education network for nurse practitioners-family geriatric (certificate, master's option).	219,126
University of Miami, Coral Gables, Fla	Gerontological nurse practitioner (master's program).	61,483
Cornell University, New York Hospital, New York, N. Y.	Training program to prepare geriatric nurse practitioners (certificate program).	119,577
University of Wisconsin, Madison, Wis	Pediatric and geriatric nurse practitioner training (certificate master's option).	252,152
Seton Hall University, South Orange, N.J	Gerontological nurse practitioner program (master's degree).	111,232
Columbia University, New York, N.Y	Development of leadership programs in primary care (pediatric, adult, geriatric) (master's degree).	328,039
University of Lowell, Lowell, Mass	Graduate program: Gerontological nurse practitioner (master's degree).	144,846
Boston University, Boston, Mass	Nurse practitioner/clinician gerontological nursing program (master's degree).	136,026
University of Kansas, Kansas City, Mo	Primary care nurse practitioner-maternal child health, rural, adult, geriatric (certificate program).	127,256
University of Utah, Salt Lake City, Utah	Family gerontological program (master's level)	247,776
Total		2,097,250

Special project grant activities in 1980 under section 820 of the PHS Act have supported grants targeted toward curriculum revision, with a major focus on gerontological nursing, continuing and inservice education activities to upgrade and maintain competency and skills of practicing nursing personnel which include, but are not limited to, gerontological or geriatric content. A total of $1,423,753 was allocated in fiscal year 1980 to the following special project activities:

A. CURRICULUM REVISION GRANTS WITH A GERONTOLOGICAL/GERIATRICS FOCUS

Applicant	Title	Fiscal year 1980 support
Augustana College, Sioux Falls, S. Dak	Gerontological integration and practicum in nursing major.	$41,500
Niagara University, Niagara, N.Y	Gerontological concepts in nursing practice	80,386
University of Tennessee, Memphis, Tenn	Primary care of the aged in the baccalaureate curriculum.	70,589
University of Maryland, Baltimore, Md	Gerontology training program for nurse educators	45,891
Emory University, Atlanta, Ga	Community learning experiences to improve curricula	141,031
Carroll College, Helena, Mont	Improvement of baccalaureate nursing curriculum	50,222
University of Miami, Miami, Fla	Enhancement of a nursing curriculum to address health manpower needs.	61,371
Total		490,990

B. CONTINUING EDUCATION GRANTS WHICH INCLUDE GERONTOLOGICAL NURSING CONTENT

Applicant	Title	Fiscal year 1980 support
University of Vermont, Burlington, Vt	Continuing education program for nurses	$59,910
Old Dominion University, Norfolk, Va	Continuing education for nurses in Virginia's HSA-V	42,207
University of Rochester, Rochester, N.Y	Regional approach to continuing education	120,085
Research Foundation (Stony Brook), State University of New York, Albany, N.Y.	Continuing professional education for nurses	87,471
Arizona State University, Tempe, Ariz	Increased learning: Increasing the options	73,553
Hospital General de Castaner, Inc., Castaner, Puerto Rico.	Continuing education for nurses in rural areas	71,792
Michael J. Owens Technical College, Toledo, Ohio.	Program for continuing education for nurses	30,270
University of Pittsburgh, Pittsburgh, Pa	Regional continuing education in nursing	195,505
Total		680,793

C. INSERVICE EDUCATION WITH A GERONTOLOGICAL/GERIATRIC FOCUS TO UPGRADE SKILLS OF LICENSED PRACTICAL NURSES, NURSING ASSISTANTS, AND OTHER PARAPROFESSIONAL PERSONNEL

Applicant	Title	Fiscal year 1980 support
Westbrook College, Portland, Maine	Geriatric nurse assistant	$31, 575
Donnelly College, Kansas City, Kans	Upgrading skills of aides/orderlies in nursing homes	16, 880
Miami Jewish Home and Hospital for the Aged, Miami, Fla.	Nursing special project grant	74, 343
St. John's Medical Center, Tulsa, Okla	N.E. Oklahoma continuing education project	129, 172
Total		251, 970

The following 20 advanced nurse training active projects under section 821 of the PHS Act provide support for the preparation of nurses in gerontological nursing at the graduate level. Some of these projects are exclusively devoted to gerontological nursing, while others, include a significant content area:

Applicant	Title	Fiscal year 1980 support
San Jose State College, San Jose, Calif	Gerontological nurse specialist program	$100, 198
University of Delaware, Newark, Del	Advanced nursing training program	123, 625
University of Kansas, Kansas City, Kans	Training of gerontological clinical nurse specialists	58, 930
University of California, San Francisco, San Francisco, Calif.	Graduate program in long-term/gerontological nursing	156, 231
University of Pennsylvania, Philadelphia, Pa	Gerontological nurse clinician	59, 407
University of Kentucky, Lexington, Ky	Outreach master's program	101, 599
University of Michigan, Ann Arbor, Mich	Ph.D. program in nursing	213, 687
George Mason University, Fairfax, Va	Master of science in nursing	107, 994
Case Western Reserve University, Cleveland, Ohio	Post baccalaureate program in gerontological nursing	146, 649
Montana State University, Bozeman, Mont	Nursing specialists for underserved rural areas	89, 010
Indiana University, Indianapolis, Ind	Expansion of a doctor of nursing science program	131, 003
University of Maryland, Baltimore, Md	Doctoral education for scholarly nursing leadership	192, 313
University of Wisconsin, Madison, Wis	A program in community/gerontological nursing	74, 293
Georgetown University, Washington, D.C	Graduate nursing program	211, 370
Syracuse University, Syracuse, N.Y	Preparation for nursing of the rural aging	91, 227
Murray State University, Murray, Ky	Preparing rural clinician focus on aging and child	188, 159
University of Rochester, Rochester, N.Y	Gerontological nursing: Major and minor emphasis	85, 032
University of Oregon, Portland, Oreg	Medical-surgical nursing: A gerontological focus	177, 126
Duke University, Durham, N.C	Advanced training for leadership in nursing	177, 963
State University of New York, Binghamton, Binghamton, N.Y.	Master of science clinical nurse specialist program	95, 530
Total		2, 581, 346

The purpose of the following new research project grant under section 301 of the PHS Act is to identify components of health care provided to elderly women by nurse practitioners in primary ambulatory care settings which contribute most to patients' satisfaction and to their intent to adhere to the plan for their care. This is a 2-year project with an estimated total cost of $109,467.

Applicant, University of California, Los Angeles, Calif.; Title, Elderly Women's Evaluation of Nurse Practitioner's Care; fiscal year 1980 support, $75,271.

DIVISION OF MEDICINE

Grant and contract program support under title VI of the Public Health Service Act included geriatric activities. Under section 781(a), the University of Maryland School of Medicine received $87,000 to continue its development of an area health education center program which includes graduate and undergraduate geriatric medical training in an urban geriatric setting.

Twenty-five grants ($1,988,275) were awarded under section 788(d) to support the development, implementation, and evaluation of new geriatric course materials. Approximately half of the grants were in schools of medicine. The rest were distributed among schools of dentistry, optometry, pharmacy, public health, nursing, and allied health. The curriculum development grants are multidisciplinary, in many instances, and range in scope from a course on gerontology to a mobile health unit staffed by students.

The section 788(d) authority was also used to fund other efforts. First, the American Geriatric Society in New York received $199,081 for the final year of a 2-year contract to develop and implement a model geriatric undergraduate primary care curricula. Second, the minority-oriented primary care medical education program awarded $1 million to Morehouse Medical College where geriatrics specifically will be included in the curriculum to train primary care physicians to practice in medically underserved rural and inner-city areas.

Under section 786(a) the final year of a 2-year contract ($194,281) was awarded to the Gerontological Society of Washington, D.C., to develop a self-instructional model for the management and care of elderly patients. The New York State University Research Foundation received a 2-year contract ($126,487) under section 786(a) to develop, implement, evaluate, and disseminate a self-learning program in alcohol and alcohol abuse (one of the curriculum modules will be "Drinking and the Elderly"). Additionally, a number of training programs under this section have received funding specifically for the area of geriatrics. For example, the University of Maryland has received $21,240 to train its residents in geriatrics. The Medical Center of Beaver County, Inc. (Rochester, Pa.) pays 10 percent of the salary of the director of geriatrics training and medical director of Beaver Valley Geriatrics Center to teach courses in this area. The University of Louisville (Kentucky) received $366,769 in part to develop and implement a geriatric clinical program for its residents. Duke University Medical Center trained 39 residents in geriatrics and pharmacotherapeutics. The University of Minneapolis and the University of Colorado (Denver) were awarded $11,333 and $40,000 respectively to strengthen their curriculum activities in geriatrics.

A number of activities occurred under section 783(a) which had a direct or indirect impact on the elderly. Northeastern University developed a course on the aging process for its physician assistants (PA's). The University of Nebraska, as a part of its emphasis on geriatric education for PA's, received $1,200 to examine the psychosocial aspects of gerontological care. The Charles R. Drew Post Graduate Medical School received support for curriculum development and advanced training in geriatrics for graduate PA's and the University of Oklahoma Health Science Center received $20,700 to develop geriatric curriculum modules for its 60 trainees.

Over 30 grantees in the general internal medicine and general pediatrics residency program (section 784) have indicated the intent to provide training in the area of geriatrics.

DIVISION OF DENTISTRY

The provision of adequately trained professionals available to deliver primary dental care services to the geriatric patient is a major target area. Traditional delivery methods do not always provide access to dental care for many of these individuals both in terms of availability and cost. Training support is available through general practice residency programs which, in some instances, are in hospitals providing comprehensive dental services to the elderly, and in the capitation program which has an extramural training requirement directed at underserved population groups that include the elderly. Over 25 percent of the schools participating in the capitation program conducted remote site training activities within geriatric health care facilities.

A curriculum development grant ($65,140) was awarded to the University of Iowa School of Dentistry for education in geriatrics. Three other awards included dentistry in an interdisciplinary approach to education in geriatrics. The purpose of the grants are to facilitate efforts to instruct future health care practitioners about the health needs of the elderly in order to assist them to lead maximally productive and independent lives. Specifically, it is intended that these grants will lead to the development and implementation of new courses or segments of courses and training experiences devoted to the unique health care needs of the elderly.

HEALTH SERVICES ADMINISTRATION

I. INTRODUCTION

The Health Services Administration (HSA) is the agency within the Public Health Service (PHS) responsible for providing a comprehensive array of health care services to the medically unserved and underserved as well as statutorily defined beneficiary population groups such as American Indians and Alaska

Natives, migrants and seasonal farmworkers, and merchant seamen. The HSA administers and operates numerous health care programs which are available to older Americans as part of a broader beneficiary population. The Bureau of Community Health Services (BCHS) funds and administers over 1,200 primary health care projects and 61 grants to home health agencies. The Indian Health Service (IHS) operates 49 hospitals and over 300 clinics and field stations that provide health care to Indians living on and near reservations. The Bureau of Medical Services (BMS) operates 9 PHS hospitals and 27 freestanding clinics that provide medical services to such groups as merchant seamen and members of the Armed Forces and dependents.

It is well known that even with all the health care programs and services available to the elderly, millions of older persons often do not receive either adequate treatment for their chronic conditions or regular and comprehensive health care. This is due to a variety of factors including: A shortage of medical, nursing, and dental personnel; a generally fragmented and uncoordinated health and social services delivery system; and conflicting regulations and benefit packages.

Moreover, the health needs of older persons are diverse and wide ranging and cross traditional program approaches. For this reason, the HSA, primarily through community health centers (CHC's), migrant health centers, the National Health Service Corps (NHSC), hypertension and home health programs, as well as special health care initiatives promoted by the IHS Committee on Aging, is coordinating efforts to develop new approaches to better serve the elderly and the chronically impaired older person. As described below, interagency linkages and coordination have become a focus for such efforts.

HEALTH SERVICES ADMINISTRATION PROGRAMS

A. COMMUNITY HEALTH CENTERS

In fiscal year 1980, CHC's located primarily in medically underserved areas, provided a range of preventive, curative, and rehabilitative services to 4.2 million persons, of which 7.9 percent were 65 or older.

Formal and informal linkages have been established between some center grantees, the U.S. Department of Agriculture (USDA), and the Administration on Aging (AoA) to augment the number of social and nutritional programs available. These programs include the food stamp program, the meals-on-wheels projects, and programs in which the CHC's provide services to seniors in congregate housing and sponsor multiphasic screening clinics in senior citizen centers and recreational areas. Other linkages include transportation arrangements with long-term care institutions and individual service arrangements with nonprofit senior centers and home health agencies. Special efforts have been made to integrate home health services into a comprehensive medical care package as evidenced by the certification of several CHC's as medicare home health providers.

B. MIGRANT HEALTH

The migrant health centers program provides health care services for migrant and seasonal farmworkers and their families. Migrants live and work in predominantly rural areas where health resources are scarce. The elderly migrant, beset by increasing health problems, is placed in a vulnerable position—faced with inadequate health resources and manpower, and language and cultural barriers. In fiscal year 1980, services were provided to 581,000 migrant and seasonal farmworkers through 122 projects. Approximately 5 percent of those served were 65 or older.

The migrant health centers program authority, section 329 of the PHS Act as amended November 1978, includes language that broadens eligibility to include a significant number of elderly and disabled. With the new legislative authority, the migrant health centers program can serve "individuals who have previously been agricultural workers but can no longer because of age or disability, and members of their families within the area it serves."

C. NATIONAL HEALTH SERVICE CORPS

The NHSC was designed to improve the delivery of health services by providing health manpower to persons residing in communities designated as having a health manpower shortage. One of the factors used to determine whether an area has such a shortage is the percentage of the area's population that is age 65 or older. The NHSC recruits and places health professionals in these areas. Since older persons residing in such areas often have reduced mobility, the presence of health personnel in their communities is of special importance. In fiscal year 1980, a total of 1,201,310 people were served by 2,058 Corps assignees. Of the number served, approximately 10 percent were age 65 or older. The Corps is closely integrated with the CHC and migrant health programs, providing assistance in recruiting health manpower for these programs. The estimated NHSC expenditure level for services for the 65 and over population in 1980 was $8,056,000.

In 1980, workshops focusing on geriatric medicine and other gerontological issues were conducted at five of the NHSC inservice conferences for NHSC assignees. Also, a series of case studies on issues in community health, to be done in 1981, will include a special case study on geriatric health care. These studies will be conducted at regional conferences or workshops at individual medical schools, and will be used to familiarize scholarship recipients with geriatric health concepts.

D. HOME HEALTH

Designed to offer medically desirable and often cost-saving alternatives to institutionalized care in hospitals and nursing homes, the home health program is specifically directed toward meeting the needs of the elderly by providing skilled nursing and therapeutic services in their homes. The program, administered by BCHS, awards two types of grants. One type is awarded to meet the initial costs of establishing and operating home health agencies in areas where such services are not otherwise available and to expand services available through existing agencies. The other grant type is awarded to train professional and paraprofessional personnel to administer and provide home health services. In awarding grants, the relative needs of States are considered. Preference is given to areas within a State in which a high percentage of the population to be served is composed of persons who are elderly, medically indigent, or both.

Prior to the establishment of the home health program in 1976, there were 788 counties in the Nation without the services of a medicare certified home health agency. As a result of the program, home health services are now available in 175 counties where such services were not available before the grant program. Home health services have been expanded so that these services are now available in 550 counties. In fiscal year 1980, a total of 61 service grants were awarded providing for the development of 15 new agencies and the expansion of 46 others. In addition, 22 training grants provided for the training of home health agency staff to enable them to upgrade the quality of patient care delivered and improve the administrative efficiency of the home health agency. As part of this effort, a curriculum and training guide was developed and distributed, which preliminary evaluation studies indicate have greatly improved the quality of care provided by home health aides. Since the inception of the program in 1976, a total of 345 home health agencies have been funded. Of those agencies, 85 were new and 260 were expanded. A total of 65 training grants has provided training for over 10,000 home health personnel. These activities have greatly increased the opportunity for homebound patients, predominantly older persons, to receive necessary adequate health care services.

E. HYPERTENSION

The hypertension program was established as a formula grant program providing funds for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension. In fiscal year 1980, the program continued to expand its focus on this condition which affects a significant proportion of the aging population. Key clinical indicators were used for assessing the effectiveness and quality of care in primary care centers. One of these requires that blood pressure measurements be done regularly on patients age 10 and over. The centers were held responsible for making sure that all patients with elevated blood pressure received followup services. Effective fiscal year 1980, the program changed from a formula grant to a project grant program. This change resulted in greater accountability, promoted uniform reporting, and insured that funds are targeted where the greatest benefit can be derived. It is estimated that screening services were provided to 7.8 million persons (among whom were a significant number of elderly).

F. THE INDIAN HEALTH SERVICE

The Indian health program provides health services to approximately 795,000 American Indians and Alaska Natives, many of whom reside on 250 reservations and Indian communities in 28 States and hundreds of villages in Alaska. It is estimated that 6 percent (48,000) of the American Indian and Alaska Native population is 65 and over. There is a preponderance of younger persons in the IHS population; the Indian and Alaska Native median age is 18.4 which is lower than the median age of 28.1 for all races in the United States. However, attention is being focused on the needs of the elderly primarily as a consequence of the 1978 Indian Conference on Health of the Elderly conducted by the National Indian Council on Aging.

Specific services and interagency linkages have been geared to serve the special health needs of the elderly. Services offered in conjunction with the AoA include congregate meals, meals-on-wheels, minor home repair, shopping assistance, transportation, health surveillance, outreach, and part-time employment. Other linkages include IHS medical and social service surveillance for nursing home and extended medical care patients, and assistance in obtaining services under medicare, medicaid, the USDA-administered food assistance program, Veterans' Administration, and other Federal and State programs.

G. PUBLIC HEALTH SERVICE HOSPITAL CARE

Health care services within the BMS, Division of Hospital and Clinics, are provided by 9 PHS hospitals (8 general medical-surgical and 1 specialty hospital for the treatment of Hansen's disease), 27 freestanding outpatient clinics, and more than 300 contract physicians and hospitals located throughout the United States. During the first 6 months of fiscal year 1980, of the 35,106 discharges from the PHS hospitals, in 9,900 instances, the patient was 60 years of age or more. Annually, it is estimated that approximately 149,100 inpatient days were utilized by this group at an estimated cost of $29,223,600, an average daily rate of $196. The average length of stay of 15.1 days for this age group is longer than the average for younger individuals. American seamen constitute a major PHS beneficiary group. There are probably more single males in this category than in the population at large. As a consequence, finding suitable nursing homes or other protective settings constitutes one of the major difficulties in discharge planning. During fiscal year 1980, it is estimated that patients 60 years of age or over made 512,500 visits to hospital emergency rooms, outpatient clinics or to freestanding clinics at a cost of $41 per visit. The total cost for outpatient care for this group, based on the above data, is estimated to be $21,012,500.

1. Hospital-Based Geriatric Day Treatment and Screening and Referral Services

The geriatric day treatment center (GDTC) has been operating on the campus of the PHS hospital, Baltimore, Md., since January 1976. It is jointly sponsored by the Family and Children's Society of Baltimore and the PHS hospital. Through a contract with the Maryland State Department of Health and Mental Hygiene, Office of the Chronically Ill and Aging, the GDTC received title XX of the Social Security Act funds. Each year the program has been in operation, title XX funds have increased. This program provides an alternative to institutionalization. Services are delivered by a multidisciplinary staff in a protective group setting. The program is structured around an organized regimen of activities of daily living and health services. Additional important program components include nutrition counseling, psychiatric consultation, and transportation. Family members are counseled and taught various techniques to increase their ability to be helpful to the program participants in the home. Program participants are persons 60 years of age and older referred from PHS beneficiary groups, the geriatric evaluation service of the Baltimore City Health Department, community organizations, and private physicians.

The GDTC program has continued to grow and expand in 1980. Building on this framework of services, the GDTC was selected to serve as a demonstration model for the HSA/AoA demonstration, to be described later.

The PHS hospital in San Francisco has operated a geriatric screening and referral service (GSRS) since 1977. This program was developed with several community groups and the San Francisco Health Department to examine persons 60 years of age and over who live in the Richmond and Sunset districts of

San Francisco. The goal is to maintain people at the highest level of functioning and self-sufficiency as possible. The staff includes a nurse practitioner and personnel from the PHS hospital and the San Francisco Health Department. Program participants receive a complete history and physical examination, laboratory workup, social work interview, and immunizations as appropriate, for example, flu vaccine. They are referred for eye and hearing examinations and for other services as needed. The scope of services also includes followup on an annual basis and more frequently if indicated. The GSRS works very closely with the San Francisco District No. 5 Community Board, which has a geriatric protective service and with the Richmond RAMS group which is a multilanguage, multicultural, yet predominantly Chinese, mental health program. The GSRS clinical sessions are held once a week and see 5 to 10 persons per clinic session. The number of patients served by the GSRS program in fiscal year 1980 was 294.

2. *Hospital-Based Nutrition Programs*

The PHS hospital in Boston established its nutrition program for the elderly in 1977. This program regularly services lunch to more than 75 people 60 years and over, 5 days a week. In addition to lunch and the associated socialization, nutrition information, and counseling are integral parts of the program. Further, the program has stimulated much interest in the possibility of linking these nutrition services with other services integral to the provision of primary care. Over the next year, efforts are being made to develop a wider scope of health and social services for program participants. Cost of the program during fiscal year 1980 was $63,027 for a total of 11,952 meals served.

3. *Other PHS Hospital Programs for the Elderly*

The San Francisco PHS Hospital has recently set up an extended care unit established to fill the need for extended care for "hard to place" patients drawn from the hospital's general medical and surgical wards, most of whom are over 60 years of age. The unit was opened during the last quarter of fiscal year 1980, and will be expanded during fiscal year 1981.

The Seattle PHS Hospital has a unique program for the rehabilitation of stroke and cardiac patients within the department of physical medicine and rehabilitation. An interdisciplinary team approach is used in patient treatment. The program is staffed by psychiatrists, physical therapists, occupational therapists, and nurses, and is affiliated with a teaching program at the University of Washington Medical School. Stroke patients are treated by the spinal cord injury team. Those over 60 years of age approximate 20 percent of all patients treated. Cardiac patients over 60 years of age approximate 60 percent of all cardiac patients treated. It is estimated that the cost of treating patients over 60 years of age in these programs during fiscal year 1980 was $50,500 for a total of 670 inpatient days and 1,020 outpatient visits. In addition to treatment programs, the Seattle PHS Hospital Occupational Therapy Department is presently conducting research on the "Development and Testing of a Scale to Measure the Activities of Daily Living of the Disabled Population." This research will have a great deal of impact on PHS programs for the population specified, many of whom are functionally disabled. The cost of the research will be absorbed by the occupational therapy department.

The Staten Island PHS Hospital has developed a "cancer support" program for patients who have the diagnosis of carcinoma. It is estimated that at least 75 percent of these patients are over 60 years of age. All patients with this diagnosis, whether inpatient or outpatient, are referred to the program coordinator. Weekly meetings are held for patient support and education. A group of individuals from the hospitals volunteer to visit patients at home, so that patients and their families may receive the support needed to remain together. The "cancer support" program will receive funds from bazaars and other functions held by the hospital to raise money for patients. It is hoped that funds received from these activities will help provide patient transportation services in the future. Staff inservice education is an ongoing component of the program. The estimated cost of the "cancer support" program for the population specified is $17,900 for a total of 5,780 inpatient days and 1,120 outpatient visits. It should be noted the actual treatment costs for these patients are counted within general medical-surgical and outpatient department costs. Thus, the figure of $17,900 reflects only the support function.

An additional program developed by the Staten Island PHS Hospital is the restorative care unit. The unit is organized to provide rehabilitation services to such patients as amputees, stroke and accident victims, and long-term post-operative orthopedic patients. It is estimated that 80 percent of the patients served by this unit in fiscal year 1980 were over 60. Patient days totaled 2,922. The unit is staffed by one physical therapist. Costs are difficult to estimate as the referring services, such as the neurology and orthopedic departments, absorb the costs for patients referred. It is important to note that this unit serves a patient population for whom most community hospitals do not provide service.

III. The Health Services Administration—Administration on Aging Demonstration Program

Recognizing the need of a growing elderly population for quality comprehensive health care combined with increasingly scarce program dollars, the HSA is concerned with integrating and coordinating services in order to create more effective and efficient health care delivery programs. A major initiative in 1979 was an HSA/AoA interagency agreement to develop program and funding linkages to increase the number and scope of health services available to older persons as well as coordinate efforts to address the social needs of the elderly.

The specific goals of the joint initiative are to be implemented on a limited demonstration basis over a period of 3 years. They are as follows:

—To increase the access of older persons to health care services in HSA-sponsored facilities within a given geographic area.

—To encourage opportunities for development of program planning, funding, and coordinating linkages between HSA-sponsored facilities and State and area agencies on aging; and

—To utilize the funding, manpower, and facilities available to area agencies on aging, HSA-sponsored facilities, and Indian tribal organizations to develop a comprehensive package of health and social services directed at the underserved and unserved elderly population within a given geographic area.

The funded demonstration projects aim to seek solutions to problems of older persons whose independence and self-sufficiency are threatened, and those whose ability to remain in their homes or to avoid institutionalization depends on family and community assistance for support. The projects also seek to resolve barriers to effective health/social care within a community setting, that is, they must seek to overcome service fragmentation and problems of community service coordination.

Eleven demonstration projects were developed (eight of these were funded during 1979 and are within their second year of funding). The demonstration projects focus on various services delivery models and approaches to increase and link health and social services to older persons in three HSA delivery settings: CHC's; PHS hospitals and clinics; and Indian tribal organizations/agencies supported by the IHS. The projects are summarized below.

A. COMMUNITY HEALTH CENTERS

Five CHC's are serving as model projects under the joint HSA/AoA demonstration initiative to provide information to the HSA as to how its primary care centers may better serve the elderly and the chronically impaired older person. The projects will identify the components of a program necessary to provide comprehensive services to meet the plan of care for each individual in the target population. Such components include outreach to potential recipients of services, health education and screening, nutrition education and counseling treatment (preventive, diagnostic, therapeutic), home care, and transportation. Each project must then provide such services either directly or through linkages with the area agency and community providers.

One such project is the San Ysidro Community Health Center demonstration in the South Bay area of San Diego. This project is concerned, in particular, with providing community outreach and health education services for a target population largely of Hispanic elderly who often do not use the health care services available to them as a consequence of real and perceived cultural barriers. A multidisciplinary team comprised of health educators, physicians, social workers, community health assistants, and health aides bring a full range of coordinated health and social services to the elderly in that area. Linkages have been established with the three senior citizen centers and two nutrition centers in order to introduce and engage the elderly in the area into the service network.

The Boriken Neighborhood Health Center (BNHC) demonstration project in East Harlem, N.Y., is oriented to meeting four principal objectives. First, to meet the social and health needs of elderly, the BNHC is increasing the amount and scope of the health services offered. Second, to improve quality of care, the BNHC is developing a health team with expertise in prevention, diagnosis, and treatment of prevalent health problems/conditions among elderly. This bilingual team is composed of one physician, one nurse practitioner, three community health workers, one health educator, and a part-time social worker. Third, permanent linkages have been established between the BNHC, senior centers, and nutritional programs for the elderly to offer integrated social and health services. Fourth, formal structural linkages within existing social and health care delivery systems are being developed in East Hariem through the organization of an advisory committee with consumer and provider representation and through the involvement of the staff and clientele of participating senior centers in the planning and implementation of a comprehensive health care plan.

The Providence Ambulatory Health Care Foundation, which maintains seven CHC's in Providence and a geriatric health care clinic, is improving the health status of an elderly population living in designated census tracts by establishing linkages with other elderly serving agencies such as the Visiting Nurse Association of Providence, the Rhode Island Department of Elderly Affairs, the Providence Mental Health Center, Project Hope, and the Volunteers Intervening for Equity. Participating agencies will cooperate through establishment of reimbursement agreements, utilization of common referral forms, placement of all service information on the applicant agency's case record, and the monitoring of all care or services provided by the case manager from the applicant agency.

The Neighborhood Health Center, Inc., St. Louis, Mo., has developed a neighborhood-based case management system to provide outreach, assessment, plan of care, linkages, monitoring, advocacy and evaluation/reassessment to frail and semifrail elderly. It links and interfaces a variety of health-related services into a continuum of care network. Thus, 75 percent of the elderly in select neighborhoods can be identified and contacted. A continuum of services are being developed through the reconfirming of existing and establishment of new interagency linkages. Individualized service plans are implemented for 240 to 280 at-risk elderly neighbors. Gaps in services can be identified and solutions investigated. Finally, potential for replication of this system will be examined.

Senior Care, sponsored by the D.C. General Hospital, Washington, D.C., is coordinating efforts to improve the care of an elderly underserved population of 28,000, in the inner-city of the District of Columbia. An outreach program is being developed to increase the number of elderly in the defined service area who are receiving care in three inner-city CHC's (the Shaw Community Health Center, the Community Group Health Foundation, Inc., and the East of the River Health Association) and also to improve the quality of services the elderly receive in the general medical clinic of the D.C. General Hospital. This project relies on a nurse facilitator, a planner/administrator, three outreach workers, and an evaluation assistant. Project evaluation is performed by the Department of Community Medicine and Family Medicine of Georgetown University School of Medicine. Specific outcomes of utilization, health status, and patient satisfaction can be measured.

B. PHS HOSPITALS AND CLINICS

The BMS projects involve the funding of demonstration projects which focus on the elderly residing in the immediate geographic area served by three PHS Hospitals. The demonstration projects share the common goals of improving availability and the accessibility of services for the chronically impaired and frail adult.

The PHS Hospital in Baltimore, Md., proposes over the next 3 years to establish a geriatric health service that will provide a comprehensive set of medical-psychological services for a defined population of elderly persons. The project will develop several points of entry into the system by locating in existing community organizations, such as the Action in Maturity and the Northwest Senior Centers; develop a network of service provider points such as hospitals, CHC's and private practitioners; develop an integrated system of referrals to already existing psychosocial services; and arrange for the transportation and tracking of elderly clients through the system. The staffing of the geriatric health unit will consist of a full-time nurse practitioner, social worker, secretary, and part-time health educator and physician.

The goal is to maintain and/or improve the functional ability of noninstitutionalized residents of Baltimore over the age of 60 through:

—Detection of disease and psychosocial problems in the elderly.

—Provision of limited primary health and social services.

—Providing a referral mechanism for appropriate medical treatment and psychosocial assistance.

—Conducting of health education programs.

This project will concentrate on meeting the health and psychological needs identified by community surveys in the Hampden-Woodberry-Remington area, the needs assessment of the area agency on aging, and those problems identified by case management at the participating senior centers. To the extent feasible, the project will try to become financially viable through third-party payments and a self-pay program for the clients. A sliding fee schedule will be instituted.

The PHS hospital in Boston, Mass., is located in the Allston-Brighton area which has a population of approximately 12,000 elderly aged 60 and over. Although social services are available for the elderly in the area, certain social needs continue to be identified, such as transportation, some housekeeping, and crime protection. Further, the supply of primary care in the area is inadequate. Between 1,000 and 2,000 elderly have reported problems with health status. Five percent of Allston-Brighton elderly are homebound. In 1978, a survey conducted by the Boston Commission on Affairs of the Elderly reported that about 17 percent or 2,000 of the population 60 years and older living in the Allston-Brighton area had no contact with a physician during that year. Further, half of the eight census tracts are identified as either a medically underserved area or a health manpower shortage area. The PHS intends to mobilize its resources in order to help alleviate problems of availability and accessibility of primary care. To carry out this purpose, the PHS will develop a primary care program aimed specifically at the elderly in Allston-Brighton. It will utilize physicians, nurse practitioners, case aides, and other specialty services in order to provide health treatment, education, nutrition counseling, health detection, and other services. In order to provide a comprehensive package of services to the elderly, the PHS will develop model linkages to the social services/health care system. The PHS will offer its services regimen at the hospital ambulatory unit, at the home site, through mobile clinics in the community, and at the PHS nutrition program currently in operation.

AoA funds have been requested jointly by the PHS hospital in Seattle, Wash., and the Central Seattle CHC, a BCHS grantee, to link primary care services with senior center activities, home health care, and chore services. Medical backup for outpatient, inpatient, and rehabilitative services is included. Participating agencies are the PHS hospital, Pike Market Community Clinic, Market Senior Center, neighborhood health centers, Seattle-King County Health Department, Visiting Nurse Service, Harborview Medical Center, Virginia Mason Hospital, Homemakers Upjohn, and Seattle-King County Division on Aging.

There will be a phased approach focusing on downtown Seattle in fiscal year 1981, developing additional projects in south Seattle in years 2 and 3. The overall goal is to create a citywide system of coordinated elderly services helping older adults remain independent active members of their communities with decreased reliance on high-cost health care. Project objectives include: The development of a well-coordinated package of health and social services emphasizing independence, self-esteem, and dignity; and the improvement of coordination between health and human service agencies serving the elderly by maximizing the use of home health services to replace short- or long-term care. To accomplish these objectives, AoA funds will support a nurse practitioner, outreach worker, social service advocate, public health nurse, health aide, and patient advocate. These individuals will provide primary geriatric health care; outreach services, including casefinding, patient education, referrals; patient advocacy for legal, housing, employment, food, and other social services; health screening; home visits; footcare; and patient advocacy in hospital settings. Project coordination in fiscal year 1981 will be the responsibility of the Pike Market Community Clinic, a member of the central Seattle consortium.

C. INDIAN TRIBAL ORGANIZATIONS

The Yakima Indian Nation, in conjunction with the IHS and its area agency on aging, propose to supplement preventive health care, develop coordination methods for social and health services to the Indian elderly, and establish a certified inhome health program on the Yakima Indian Reservation. Professionals in the program, or through other coordinating offices, work with the client and his family to develop an individual care plan promoting a maximum level of health and activity independence. The demonstration project provides for a community health nurse, part-time licensed physical therapist, three homemakers, and three home health aides. These staff members work solely for the Indian elderly, aged 60 years and over. This grant was awarded in the amount of $84,363 for fiscal year 1980.

The geriatric health program developed by the Cherokee Nation will provide preventive health care services to Cherokee elders by the establishment of programmatic linkages with existing health care and human service agencies in the Cherokee Nation, the provision of extensive community and individual counseling, increased involvement of the Cherokee elder in community activities, and an emphasis on preventing and promptly treating illness. The staff of the geriatric health program, which consists of a director, two bilingual geriatric specialists, two elderly health aides, and one licensed practical nurse, coordinate the efforts to improve the health status of the Indian elder in the Cherokee Nation. This grant was awarded in the amount of $96,637 for fiscal year 1980.

The intent of the Navajo Nation project is to demonstrate the use of geriatric nurse specialists to increase the access of high-risk elderly to primary health related services in the Navajo Nation. The principal aims of the project are: To assist in the identification of Navajo elderly at risk of being institutionalized; to increase the access of this group to health care of all types; and assess and eventually improve existing system of referral, followup, and case coordination. Involved in this demonstration project will be the Department of the Divisions of Health Improvement Services and Social Welfare, the community health nursing program and various agencies within the Office of Direct Care Services of the Navajo area. The IHS will be involved as will be the Navajo Area Bureau of Indian Affairs Branch of Social Services. Finally, programs of the Office of Navajo Economic Opportunity, such as those funded by ACTION and title V, of the Elder Americans Act, will also play a part. It is anticipated that this grant will be awarded in the amount of $84,096 in June of 1981.

IV. EVALUATION OF AGING EFFORTS

Over the long run, collaborative efforts between the AoA and HSA will build on the demonstration projects and evaluation findings with the goal being to develop methods of linking AoA/HSA resources with other health care and social services resources so as to insure the availability and accessibility of comprehensive health care to the unserved and underserved elderly. Through the implementation of these projects the AoA and HSA aim to foster the development, testing, and adoption of models which will improve the existing system of health and social services and enhance the well-being of socially and economically deprived older persons. Each funded project should be the forerunner which other agencies and organizations can adopt or adapt to their use. Projects are expected to incorporate the best of current knowledge and practice by demonstrating more effective, more acceptable, more efficient and more economical ways of serving older persons.

An evaluation methodology is being developed by the HSA to specify the analytical methods and approaches used to measure, assess, and monitor accomplishment of program requirements which have currently been established by the HSA and AoA. These requirements have been addressed by each of the successful grantees in their applications for award. There are 13 program requirements which must be met by the CHC's and PHS hospital/clinic applicants and 11 requirements imposed upon IHS grantees.

The evaluation methodology is directed toward the question of whether the demonstration projects have, in fact, improved the health status of older persons by:

—Increasing the number of older persons served in primary health care facilities.

—Increasing the amount and/or scope of services available to older persons.
—Increasing the quality of health care delivery; and
—Coordinating existing social and health service delivery systems operated by the AoA and HSA to achieve appropriate improvements in the availability and accessibility of services.

The major hypothesis being tested involves a determination of whether the above objectives can be measured, assessed, and/or monitored through the use of HSA/AoA performance requirements. It is assumed that an evaluation methodology can be built around the performance requirements and directly related to the above objectives. Similarly, it is assumed that appropriate monitoring approaches and analytical methods can be designed to continually track and assess grantee performance over a 3-year time frame.

The magnitude of grantee achievement of performance requirements will be dependent upon an array of variables associated with their particular model and target community. Those variables (demographic, socioeconomic, linguistic) will be identified and assessed in terms of impact upon the availability and accessibility and continuity (referrals) of grantee services to the aged (i.e., target population). Both the barriers and facilitating factors relating to the use of health and social services will be identified and may be used by other agencies or organizations to improve service delivery effectiveness.

In addition, the HSA is examining the services its programs presently provide for the aged. This assessment of current policy and program activities as they relate to the aged will contribute to the development of an agencywide strategy to meet the health and health related needs of a growing "older" population who are medically underserved.

NATIONAL INSTITUTES OF HEALTH

NATIONAL INSTITUTE ON AGING

Now in its fifth full year of operation, the National Institute on Aging (NIA) is working to sharpen the distinction among aging, disability, and disease. Some of the biomedical, social, and behavioral research the NIA conducts or funds may lead to ways to moderate the costs of long-term care and contribute to the improvement of the scientific basis for the diagnosis, treatment, and prevention of diseases and disabilities that occur frequently among the Nation's 25 million older persons. The NIA also focuses on the development of knowledge to promote maintenance of health and well-being in the elderly, a topic that grows in importance as the older population increases. More than that, the Institute stimulates studies and policy considerations concerning the elderly through conferences and collaboration with a variety of Federal and private organizations. This includes preparations for the 1981 White House Conference on Aging.

The intent of the Research on Aging Act of 1974, which authorized the NIA, is not only being realized in increased research on aging at universities and other non-Federal institutions of learning, but also through the vigorous research programs of the NIA's Gerontology Research Center (GRC), renowned for the scope and solidity of its investigations. The GRC program includes the Baltimore Longitudinal Study of Aging, one of the longest and largest studies of human aging. The center is a training ground for young and established scientists and clinicians, including visitors from abroad.

Thus, the Institute's work is of increasing utility to policymakers, clinicians, health professionals' education, the research community, and the lay public.

SENILE DEMENTIA OF THE ALZHEIMER'S TYPE: AN INITIATIVE

In the past year, the NIA has continued to promote research on senile dementia of the Alzheimer's type (SDAT) and related brain disorders of old age. These devastating illnesses afflict 3 to 4 million Americans, yet little is known about how to treat them effectively. The NIA funds a number of research grants aimed at finding the cause or causes of SDAT, with the hope that this will lead to guidelines on treatment or prevention.

The NIA program on epidemiology, demography, and biometry is initiating a study designed to define the causes and usual course of dementia in the elderly with particular emphasis on SDAT. The NIA has also supplemented an ongoing community-based survey of mental illness conducted by the National Institute of Mental Health. These efforts are aimed at locating victims of SDAT and determining the prevalence of dementing illness outside of institutions.

In October 1979, the Institute played a major role in bringing together a number of family groups from around the country who are interested in encouraging family services, research, and education in the area of SDAT. A national organization, the Alzheimer's Disease and Related Disorders Association, was formed at the meeting.

In early 1980, the NIA staff completed preparation of a report on the National Institutes of Health consensus development conference on treatment possibilities for mental impairment in the elderly. This report, which was published in the "Journal of the American Medical Association," outlines suggestions for accurate diagnosis of reversible mental impairment, which may account for as much as 30 percent of serious dementing illness.

WORKSHOPS AND MEETINGS

Geriatric Medicine Academic Award

In an attempt to meet the present and future training needs of medical students and physicians in the care of the aged, in 1978 the NIA introduced a new initiative, the Geriatric Medicine Academic Award. This was part of the NIA's effort to assist in the development of a curriculum in geriatric medicine in those schools of medicine and osteopathy that do not have one, to strengthen and improve the curriculum in those schools that do have one, and to foster research and careers in the field of aging. The grant includes a requirement that awardees attend an annual meeting, the first of which was held on June 16–17, 1980, in Bethesda, Md.

This meeting provided an opportunity for the 15 grantees to meet one another and the NIA staff, to exchange information, to discuss ongoing activities and future program plans, and to consider the important issue of program evaluation. Each awardee reported on accomplishments to date, and then heard presentations by representatives of other Federal agencies having a serious interest in geriatrics.

Workshop on Dietary Restriction and DHEA

In July 1980, a 2-day workshop addressed the questions of dietary restriction and the effects of the steroid dehydroepiandrosterone (DHEA) on aging, blood lipids, and tumor formation in laboratory animals. A small group of researchers interested in various aspects of these two related fields of investigation met informally to present the results of their work.

Some studies on dietary restriction (a reduction in the total number of calories consumed daily) in laboratory rats have shown that animals given restricted diets weighed less and lived longer than rats fed *ad libitum* (given unlimited amounts of food). In addition, the restricted animals had a lower percentage of fat in total body weight and developed fewer tumors later in life than did the control rats fed *ad libitum*. One investigator has also observed a decrease in the incidence of some tumors (especially mammary) in restricted mice. A separate but related observation is the apparent antiobesity and antitumor effects of treatment with DHEA in mice. The workshop participants agreed on the need for future studies to confirm these preliminary findings.

Research Frontiers in Aging and Cancer: International Symposium for the 1980's

The possibility that aging and cancer involve similar body processes was explored at an unusual scientific meeting, held September 21–26, 1980. Supported by the NIA, the National Cancer Institute (NCI), and Bankers Life & Casualty Co., the meeting represented a government-private sector partnership to spur research in the fields of aging and cancer.

Approximately 45 well-known scientists, including five Nobel laureates and one who later received a Nobel Prize, presented the results of current research on such topics as the organization of genetic material; regulation of gene activity; viruses in aging and cancer; and aging and cancer as genetic phenomena.

The symposium concluded with formal hearings before the House Select Committee on Aging, chaired by Congressman Claude Pepper. Testimony was presented by the Directors of the NIA and the NCI; Lewis Thomas, M.D., president of the Memorial Sloan-Kettering Cancer Center and chairman of the symposium; and the chairmen of the meeting's eight scientific sessions.

This symposium was the starting point for a series of future workshops to deal with other aspects of aging and cancer research. It also provided the impetus for a cooperative arrangement between the NIA and the NCI to include geriatric patients in appropriate studies designed to evaluate new methods of cancer treatment.

Biological Mechanisms in Aging Conference

Opportunities for research to refine or validate current theories of aging or to formulate new theories were explored at an NIA conference on Biological Mechanisms in Aging in June 1980. Some 100 leading scientists—in fields ranging from genetics and molecular biology to endocrinology and thermodynamics—attended the meeting. The focus was on seven areas of research: Mechanisms of aging and the human condition; dynamical aspects of senescence; structural pathology of DNA and the biology of aging; the influence of aging on protein synthesis; posttranslational changes (after protein synthesis) in cells and tissues; immunological aspects of aging; and neutral and endoctrine theories of aging.

The conferees not only attempted to put the latest data in context, but also to illuminate areas for future research, to identify models for aging studies, and to attract new and established scientists into aging research.

Fifth Anniversary of the NIA

In May 1980, the NIA marked the fifth anniversary of the National Advisory Council on Aging with a special meeting. A program of scientific presentations was held in addition to the normal review of grant applications by council members. Among the topics discussed were some of the findings of the Baltimore Longitudinal Study of Aging; aging in the life course in American society; and future geriatric medicine needs. The anniversary meeting was useful in gaining perspective on past achievements of the Institute, while increasing an awareness of the many areas of growth open for the future.

RESEARCH ADVANCES

Disease, Not Aging, Defeats the Mammalian Brain

The notion that serious decline in old age is the inevitable fate of the healthy mammalian brain has been challenged by GRC scientists.

Based on experiments in rats, the researchers believe that—in the absence of disease, trauma, or overwhelming stress—the aging brain does not become exhausted. Over time, the brain may lose neurons or may sustain some damage, but it has the capacity to compensate and keep going. Among the adjustments the aging brain can make is to create new cell connections to make up for lost cells, according to Stanley Rapoport, chief of the GRC Laboratory of Neurosciences.

In experiments with Fischer 3444 rats aged 12 months (young adult) and 34 months (old), GRC scientist Edythe London found no change with age when measuring regional cerebral glucose utilization, an indirect measure of cerebral function during the waking, active state. Postmortem examination under the light microscope showed no evidence of neural disease in the old rats.

By contrast, when beagle and monkey brains in old age show a decline in the same measure of cerebral function, they exhibit senile plaques (inert or dying material) and other structural abnormalities also seen in the human disease SDAT.

It is disease, not aging, that makes the difference in cerebral function as measured by regional utilization of glucose in the brains of experimental animals, says Rapoport. To describe normal cerebral function in old age, the laboratory has begun studying cerebral glucose uptake in healthy persons. After baseline values are established, the laboratory plans to study patients with SDAT and other forms of senile dementia in an effort to identify differences of potential use in diagnosis and drug treatment.

Biofeedback and Habit Retraining Can Treat Incontinence

One of the three leading reasons for admission to nursing homes is incontinence, the inability to control the excretion of waste from the human body. Aside from the health hazards and emotional difficulties related to this condition, it costs 2½ times more to care for the patient with urinary or fecal incontinence than for other long-term care patients.

Yet little is known about which patients can be trained to regain continence and how to train them. To remedy this situation, the NIA recently established a pioneer Geriatric Continence Clinic to evaluate biofeedback and habit retraining as methods for urinary and fecal control. Located on the grounds of the Baltimore City hospitals, this small, multidisciplinary research clinic may be unique in the United States. The clinic employs consulting specialists in urology, gastroenterology, and nursing; a part-time graduate student; and a guest scientist, clinical psychologist, William Whitehead, who overseas the clinic.

The clinic's training cycle takes 3 months: 1 month for baseline measurements and 2 months for training. So far, 10 outpatients aged 65 to 86 have been treated, with these results: Five have become continent, three are improved (that is, the frequency of incontinence has been reduced by at least 75 percent), and two have not benefited.

In biofeedback, the patient observes a continuously made record of abdominal and sphincter pressures as he or she tries to sense internal cues and to respond to them in a manner that changes the record appropriately. Desired responses include relaxing the bladder or contracting the anal sphincter so as to gain time to reach bathroom facilities.

Conventional habit-retraining techniques—often reserved for patients who have lost intellectual ability—either teach the individual to recognize early cues for defecation or urination, or place the patient on a voiding schedule.

If the results are sustained in a larger series of outpatients, Bernard Engel, chief of the GRC Laboratory of Behavioral Sciences, plans to expand the program to include nursing home patients whose physical and mental status may be more seriously impaired than the community-living individuals the clinic has treated so far.

The Heart: What Makes it Beat?

What makes the heart beat? By analyzing the scatter of light produced by shining a laser beam through heart muscle fiber, GRC scientists are studying the sequence of events in the excitation and contraction of the heart muscle as it beats. Understanding this process may be a steppingstone to remedies and preventives for heart failure and other cardiac diseases.

The innovative light-scatter method has shown that the heart muscle is not entirely at rest between beats. Fluctuations in the light-scatter indicate movement of calcium ions in interaction with muscle filaments.

According to Edward Lakatta, chief of the GRC's Cardiovascular Section, in many instances the light fluctuations which precede excitation of the muscle can predict the strength of the subsequent contraction. By being able to characterize basic heart action, scientists in aging can then examine changes that occur normally at various ages as well as in various disease states.

The Aging Heart: Strength Through Exercise

Direct evidence that tissue of the aging heart benefits significantly from moderate exercise has been obtained through GRC experiments in rats. These investigations also show that the tendency of the aging heart to stiffen, to take longer to contract, and to spend less time relaxed can be overcome by a relatively light exercise regimes.

In a study by Harold A. Spurgeon of the center's Cardiovascular Section, old and young rats were exercised daily for 30 minutes on a motorized wheel and were then compared to unexercised old rats and to exercised and unexercised younger rats. Muscle isolated from the exercised old rats showed a significantly shorter contraction duration than did muscle from the unexercised old rats, and was reduced to that of the younger rats.

These findings indicate that the increased stiffness and prolonged contraction duration in the old heart are not fixed, but can be modified by physical conditioning. The study has potential clinical significance by demonstrating the value of exercise in avoiding age-related impairment of heart function.

In other GRC studies, scientists have found that female subjects show the same thickening of the heart wall and slowing of ventricular filling as was previously observed in male volunteers. These findings—which were not unexpected—represent some of the first results in women since the NIA's Baltimore Longitudinal Study of Aging was expanded 3 years ago to include women as well as men.

With highly advanced techniques, 600 longitudinal participants were studied for heart flow characteristics in an attempt to find predictive measures of ischemic heart disease (caused by the constriction or obstruction of a blood vessel) as well as to portray normal changes with age in cardiac structure and function.

The techniques are: Two-dimensional echocardiography, through which an entire plane of the heart can be visualized at once during rest and during exercise; and thallium scanning, which permits left ventricular blood flow to be analyzed. Both techniques are noninvasive; that is, they require no cutting or use of indwelling tubes.

This investigation, conducted by the Johns Hopkins University under contract to the GRC, is in the third of 5 years. Investigators believe that thallium scanning of individuals during exercise may provide a useful epidemiological tool for detecting coronary heart disease. Two-dimensional echocardiography during exercise may also help to detect early disease-related changes in heart muscle function.

Saliva Flow, Taste Change Little With Time

Neither saliva flow nor keenness of taste change dramatically over the adult years in a healthy person, according to studies by GRC scientist Bruce J. Baum. Drastic change represents an effect of disease or drug, not aging.

A study of 146 healthy men and women in the Baltimore Longitudinal Study of Aging revealed that the efficiency of saliva production upon stimulation probably remains the same throughout life in healthy, nonmedicated persons. However, individuals on medication—especially postmenopausal women—did show a decrease in the flow of saliva. Baum notes that changes in the quantity or quality of saliva may set the stage for tissue deterioration in the mouth.

The belief that taste sensitivity fades dramatically with age also appears to be generally false. In a study of individuals in three age groups (20 to 39 years, 40 to 59 years, and 60 to 89 years), only 10 percent of the healthy subjects reported loss in taste, but 30 percent of those taking medications reported taste changes.

In terms of taste materials in ordinary concentrations, men show no age losses but women have a diminished perception of sweet and salt. This would tend to make women more likely to increase the amount of salty and sweet foods or flavorings they eat. With further substantiation, these findings could be useful to the elderly and their caregivers in dealing with dental decay, diabetes obesity, and hypertension.

In terms of thresholds, or lowest concentration of a tasted material to be recognized as different from water, Baum found a modest increase in saltiness and bitterness and no change in sweetness or sourness thresholds with age, irrespective of health status.

Personality Influences the Reporting of Pain

Personality appears to influence how people experience and report chest pain due to heart disease, according to an unusual study made possible by personality records gathered on individuals before they began having the pain.

Researchers at the GRC have found that individuals who are less emotionally stable have more complaints about illness than other persons. An understanding of personality styles in reporting chest pain could promote early recognition of serious heart conditions, according to the investigators, psychologists Paul Costa, Jr. and Robert McCrae and physicians Jerome Fleg and Edward Lakatta.

For example, the physician who recognizes that a patient typically does not report pain may order a precautionary electrocardiogram when that patient admits to a little bit of chest pain on exertion.

The NIA study helps to clear up confusion about the issue of whether emotional distress is a cause of the complaints or a result of illness. Personality measures were gathered on longitudinal study subjects at least 1 year before the first sign of coronary heart disease or report of angina (chest pain). These data make it possible to conclude that illness did not cause the personality differences.

Subjects who complained of angina but who lacked other evidence of heart disease were found to have the lowest scores in tests of emotional stability. They were also found to have the highest number of physical complaints before reporting their first experience of angina.

At the other extreme were subjects who never complained of angina but whose electrocardiograms indicated heart disease—they were highest in emotional stability and lowest in physical complaints. In an intermediate range of emotional stability and complaining were individuals having angina and electrocardiographic signs and individuals having neither.

Alterations in the Immune System Brought About by Dietary Restriction

Cancer is clearly recognized as one of the major diseases associated with old age. Approximately 50 percent of all cancers occur in those over 65 years old, and as more people live longer, the number of cancers in this age group will undoubtedly rise.

Evidence now points to a malfunction in the body's immune system—the defense system whereby an organism's own cells respond to and then resist disease-producing material—as a possible cause for some cancers. As part of a larger study, NIA grantees at Cornell University and the Sloan-Kettering Institute for Cancer Research in New York are examining various aspects of the immune system in older humans and animal models. As part of this work, Gabriel Fernandes has found evidence that dietary restriction markedly decreases the frequency of mammary tumors in the C3H/Bi mouse strain. When fed an unrestricted diet, the C3H/Bi mice are particularly prone to developing mammary tumors.

In addition, the mice fed restricted diets were found to have lower levels of immune complexes (a harmful combination of antibodies and antigens) in their blood. This may be a significant finding in light of other studies showing that the level of circulating immune complexes in the blood normally increases with age. Although the mechanisms are not yet clear, scientists believe that manipulation of the diet, at least in animals, plays a role in the regulation of the immune system.

Pain-Relieving Effects of Morphine Last Longer in the Elderly

Narcotic analgesic drugs—such as morphine, meperidine, and methadone—have great value in controlling pain, especially in patients with advanced stages of cancer. In elderly patients, the reduction of pain lasts longer, according to Robert F. Kaiko and his associates at the Sloan-Kettering Institute for Cancer Research. They are studying the pharamacokinetics (absorption, distribution, and elimination) of such analgesics in large groups of cancer patients of various ages. As part of this study, the researchers have carried out a well-controlled, double-blind experiment to determine the degree and length of pain relief experienced by nearly 1,000 cancer patients after morphine was given postoperatively.

The initial degree of pain intensity was similar in all age groups. When patients reported their pain as being moderate or severe, morphine was given intramuscularly. Patients were then asked to rate their relief from pain using a five-level scale (no relief, slight, moderate, nearly complete, or complete), and to indicate the duration of pain relief. At both dose levels, patients in the 70- to 89-year-old group experienced pain relief for a considerably longer period compared to other age groups. Kaiko later confirmed these results in a second population of over 1,000 cancer patients suffering from chronic pain.

Studies were also carried out to determine age-related differences in the distribution of morphine in postoperative cancer patients. Blood samples were taken from 82 patients at various intervals after the intramuscular injection of morphine, and radioimmunoassay techniques were used to determine morphine equivalents in the plasma. In patients 70 years of age or older, the highest level of morphine in the blood occurred at 48 minutes, compared to 25 minutes in younger patients. Systemic clearance studies also showed that older patients eliminated morphine from their bodies more slowly than did younger patients.

These results add further support to the growing body of evidence that, in the elderly, drugs are often cleared from the system more slowly and may therefore have longer lasting effects.

Effects of Estrogen on Incidence of Bone Fractures

Older women have a higher likelihood of suffering from fractures of the hip, forearm, and vertebrae than do younger women or men. It is generally agreed that osteoporosis, a decrease in bone density seen most frequently in older women, is the predisposing factor for this increased risk of fracture. Although the causes of osteoporosis are not entirely clear, one important factor in women is the reduced estrogen production that occurs after menopause.

In recent years, studies have shown that loss of bone density is slower in women using estrogen supplements after menopause than in women not receiving estrogens. However, it had not been established that taking estrogens will significantly reduce the risk of fractures. In an attempt to shed more light on the subject, Noel Weiss and others at the Fred Hutchinson Cancer Research Center in Seattle, Wash., have been conducting extensive surveys of postmenopausal women in the Seattle area to determine if estrogen supplementation actually decreases the risk of fracture.

Interviews were conducted with 327 women who had suffered a hip or lower forearm fracture when they were between the ages of 50 and 74. These women were asked health-related questions to determine their body's production of estrogens and their use of estrogen-containing supplements prior to the date of the fracture. The data from this survey were compared to data obtained from a random survey of 567 female control subjects, also between the ages of 50 and 74.

The results of the survey showed that women who had used estrogen preparations for 6 years or more had a 50- to 60-percent lower risk of fracture than women who had not used estrogens. However, women who had been taking estrogens for less than 6 years or who had discontinued the drugs had less benefits from the hormone treatments.

Estrogen therapy has previously been shown to increase the risk of developing cancer of the uterus. Therefore, although it now seems clearer that estrogen therapy may be one possible means of reducing the risk of fracture in postmenopausal women, this beneficial effect must be weighed against the potential risks of developing uterine cancer.

The Role of Beta Cells in Sugar Metabolism

Diabetes, a condition characterized by elevated levels of sugar in the blood, is associated with a higher incidence of heart and circulatory disease, blindness, and other disabilities. Increased blood sugar levels occur much more frequently in the elderly than in the young, although many older people may never show any of the other symptoms typical of diabetes. It is important to understand whether an elevated blood sugar level is a normal part of aging or indicates the presence of a disease which should be treated.

In most individuals, when the blood sugar level rises after a meal, the beta cells (located in microscopic structures in the pancreas called islets of Langerhans) secrete the hormone insulin, which in turn causes the tissues to take up more glucose (sugar). As a result, the concentration of sugar in the blood returns to its normal level.

The NIA is supporting a study of Eve Reaven at the Veterans' Administration Medical Center in Palo Alto which is aimed at obtaining a better understanding of the role played by beta cells in the changes in glucose metabolism seen with advancing age. She has found that islets of Langerhans isolated from 12-month-old and 18-month-old rats (whose average lifespan is 24 months) secrete less insulin in response to glucose than do islets from 2-month-old rats. However, the islet insulin content increases with advancing age as the number of beta cells and the size of the islets grow. These studies (as well as other investigations at the GRC) demonstrate that the decrease in insulin secretion occurs even though increased insulin stores are present in the older cells. Further studies are needed to define the mechanisms involved in this age-related decrease in beta cell responsiveness, and to determine whether this alteration in glucose metabolism is a normal compensation for some other age-related change or is a basic change itself.

Error Theory of Aging Examined

Scientists have proposed an "error theory" of aging, suggesting that errors in the synthesis of proteins (which combine to form enzymes) result in abnormal biological activity. This theory appears to be incorrect, according to NIA grantee Morton Rothstein, who is investigating age-related changes in the enzymes of rat tissue and nematodes (roundworms used as a model system for aging research). Rothstein and his colleagues at the State University of New York at Buffalo studied enzymes from young and old animals. Some enzymes become denatured, or inactive, as an animal ages. This may be due to changes in the enzyme's conformation (the shape it takes after folding, a process that occurs after the enzyme is completely formed).

By unfolding and then refolding the enzymes, Rothstein was able to show that enzymes from old animals retained their basic structure but that changes occurring in their conformation, not errors in protein synthesis, resulted in altered function. This has led him to speculate that the slowdown with age in the turnover of proteins allows enzymes to remain in the cell for a long time, which may result in enzyme conformation changes. This hypothesis suggests that alterations in regulatory processes may be involved in aging.

The Elderly Can Overcome Memory/Intelligence Decline

What happens to our ability to remember as we age? While it is obvious that totally losing recall of an event may signal a physical or emotional disorder, is it true that we might expect to forget some of the details of past events? Or can we expect to remember as much and as well as we have throughout life?

Researchers are beginning to understand more about memory than ever before, in part because of the relatively new way of studying memory as part of an information-processing model. Simply put, information is received and converted by the senses and then held briefly in a sensory storage, from which it is retrieved by the attention process before being lost or overlaid by other incoming information. The information is then passed on to short-term memory from which it will be transferred to a relatively permanent long-term storage. This model for the study of memory is particularly interesting to researchers in the field of aging. Not only does it provide a means of pinpointing at which stage memory may be failing, it also suggests the possibility of intervening in the process should a defect be discovered.

If there is a tendency toward increased forgetfulness with age, it may simply be a matter of failing concentration. In one aspect of his study supported by the NIT, John Horn of the University of Denver measured concentration by asking volunteers to trace a set of lines as slowly as possible while keeping their pencils moving at all times. He found that a person's capacity and/or willingness to concentrate in doing such a simple task declines with age—and may be responsible, at least in part, for what is reflected as short-term memory loss and decreased speed.

Fear of increasing forgetfulness in old age is often coupled with fear of decreasing intelligence. Horn and his associate Raymond Cattell were the first to provide a model for the study of intelligence and aging, and the first to make sense of the contradiction between the accumulation of wisdom and experience with age and the intellectual decline that may occur in some older people. Their theory suggested two kinds of intelligence: Fluid intelligence (which is thought to be related to an easily compromised function of the body's nervous system) and crystallized intelligence (a learned intelligence dependent upon education and experience). Based on NIA-supported research by K. Warner Schaie, it is generally accepted that crystallized intelligence continues to increase throughout the "vital years" of adulthood, while fluid intelligence declines in some but not all older people.

A number of theories have been advanced to explain the apparent decline in fluid intelligence with age, including decreased speed, concentration, and a failing ability to register and retrieve information on a short-term basis. Regardless of the cause, NIA-supported research is beginning to indicate that despite numerous age-related deficits, many older persons compensate, or can learn to compensate in various ways.

Horn and his colleagues find that if an older person is sufficiently motivated, he or she will show greater persistence as a compensation for decreased speed by taking the time to study a problem before abandoning it. Older persons in this study are also generally more careful than their younger counterparts, and give fewer wrong answers to problems.

In related research, NIA grantees Paul Baltes and Sherry Willis at Pennsylvania State University find that it is possible to train people to overcome decreases in fluid intelligence. Working with subjects aged 60 to 80, the research staff coach volunteers and encourage them to practice problem-solving skills designed to improve their performance on selected intelligence tests. As a result, subjects perform better on these tests, maintain the ability to perform better, and are able to transfer their training to other intelligence tasks. Thus, even though it is thought that the decrease in fluid intelligence with age is primarily a result of physiological mechanisms, it may still be possible to stop or at least slow that decrease with special training.

The NIA Explores Role of Brain Chemistry/Metals in Senile Dementia of the Alzheimer's Type

Over the past several years, investigators from a variety of disciplines have been involved in an intensive search to uncover the cause or causes of SDAT, which produces memory loss and confusion in adult life. To date, consistent—and many feel, highly promising—findings have been related to brain chemistry, specifically, the cholingeric system (a system in the brain that releases the neurotransmitter choline).

In 1976, Peter Davies and his associates reported a significant decrease in the activity of the enzyme choline acetyltransferase (ChAT) in the brain tisssue of Alzheimer patients at autopsy. With support from the NIA, Davies and his colleagues at the Albert Einstein College of Medicine have now confirmed and expanded upon these earlier findings. The most exciting results show a correlation between this change in neurochemical activity and changes in both cognition (such as memory loss and disorientation) and in brain pathology (particularly the number of plaques characteristic of SDAT seen at autopsy).

In other studies, Davies is looking at ChAT levels in the brains of persons who were considered healthy. Here he finds that many persons aged 65 to 90 have low levels of ChAT and show signs of dementia before death, but not all show the characteristic pathology (abnormal physical changes) in the brain at autopsy. By age 90, however, low levels of ChAT without physical manifestations are uncommon. This leads him to speculate that the dropoff of ChAT precedes the development of any pathological lesions like those in SDAT.

If it is true that the cholinergic system is implicated in the development of SDAT, then we are closer to the possibility of treatment than ever before. In this regard, many experts have compared SDAT to Parkinson's disease, in which a deficient chemical process is involved and the patient's symptoms can be treated by employing restorative drugs. Unfortunately, early attempts to manipulate the neurotransmitters that may be involved in SDAT have been somewhat disappointing. Much remains to be done before we can hope to treat the symptoms of SDAT with consistent success.

While some researchers have been exploring neurochemical changes in SDAT, others have been looking at the role of trace metals in the development of neurofibrillary tangles—jumbles of filaments which appear in large quantities in the outer layer of the brain as a classic feature of SDAT.

As early as 1965, investigators working with experimental animal models induced the development of neurofibrillary tangles by injecting aluminum salts. These studies stimulated Canadian researchers who, in 1973, reported an increase of 10 to 30 times the normal concentration of aluminum in the brains of individuals who had died having SDAT. Still, there has been a great deal of controversy involving the possible role of aluminum in the development of the disease.

Now, NIA-supported researcher Daniel Perl and his colleagues at the University of Vermont and the National Institute of Environmental Health Sciences have not only confirmed the findings of earlier studies, they have also devised a means to pinpoint the site of aluminum concentrations in the brain's hippocampus. Using a new, extremely sensitive method to identify and analyze the makeup of biological tissues in SDAT, they found that 90 percent of brain nerve cells with neurofibrillary tangles had aluminum in the nuclear region of the cells, while adjacent, nontangled nerve cells were virtually free of detectable amounts of the metal.

Still yet to be determined are: The role of normal levels of aluminum in the brain; how aluminum gains access to the brain; why some people may be more susceptible to aluminum uptake; and, most importantly, any cause-and-effect relationship among aluminum, neurofibrillary tangles, and SDAT.

At the present time, however, there is no evidence that consumption of food which has been cooked or stored in aluminum results in this abnormally high level of trace metal in the brain. After all, aluminum is found in all kinds of soil and therefore in airborne dust, to which everyone is exposed.

Biological Rhythms Tied to Some Sleep Problems

Biological rhythms may cause or complicate some serious sleep/wake disorders. Biological rhythms may also be responsible for deleterious, but easily correctable, changes in sleep patterns.

At Montefiore Hospital's Laboratory of Chronophysiology in New York, Elliot Weitzman allows research subjects to "free run," or establish their own schedules of waking and sleeping in a unique setting where subjects are totally isolated from any temporal clues. Weitzman finds that the subjects—some of whom are healthy elderly individuals—typically develop a schedule that more nearly approximates a 25- than a 24-hour day. Over the course of 1 month in temporal isolation, subjects slowly "phase delay"—they go to bed later and wake later each day. It is possible that this same phenomenon may occur in aged individuals in the community who are isolated from normal social cues, such as the older person who has sensory loss, or one who has retired after years of getting up at a certain hour and no longer faces the same demands.

More commonly, however, the older person tends to go to sleep earlier and wake up earlier with less sustained sleep during the night. There is a growing suspicion that these changes in sleep patterns may be caused by an age-related change in biological rhythms.

Weitzman's findings also have important implications for older persons subjected to schedules in chronic care institutions, where the times of lights on, lights out, medication administration, and meals are often dictated by operational rather than patient needs. Understanding the role of biological rhythms may make it possible to treat some of the more disturbing sleep disorders, particularly those involving phase-shift abnormalities, without depending on drug therapies.

Still, Weitzman and his colleagues do not claim that most of the problems the elderly face in their sleep/wake schedules can be explained by biological rhythms. In addition to regular fluctuations in biological rhythms, there are a number of disorders—insomnias, hypersomnias, sleep apnea, and neurological or psychiatric disorders—which cause sleep problems. Many of these become more prevalent with age.

At the 16 accredited centers within the Association of Sleep Disorder Centers (ASDC), special techniques and tools are making possible more accurate diagnosis of the range of complaints and syndromes which interfere with a good night's sleep and daytime alertness. The sleep centers also present alternatives to drugs as a cure for sleep disorders. This is especially significant for elderly patients, among whom hypnotic drug use is extensive, often with harmful results.

The sleep centers also serve as major sites for research on normal sleep/wake patterns. Although the clinical implications are not yet clear, one of the most exciting findings at Montefiore is that a person's total sleep time correlates with cyclic body temperatures but not with prior wakefulness. Under free-running conditions, a person who goes to sleep when his or her temperature is high will sleep longer.

Once the norms for biological rhythms and physiological functions are established, it may be possible to take a closer look at sleep disorders and age-related changes in sleep/wake patterns which take their toll on the routine daily activities of millions of adults.

Unsuspected Visual Handicap Among the Elderly Reported

Using the familiar eye chart to test older people's vision may significantly underestimate their eye problems. The eye chart is one of the fundamental instruments used by ophthalmologists and optometrists. It measures vision in terms of the smallest letter which can be read, and provides the practitioner with a basis for prescribing corrective lenses or therapy. Yet with the exception of reading, most daily activities depend upon a person's ability to see large- or intermediate-sized objects rather than small ones.

In a study at Northwestern University, NIA grantee Robert Sekuler compared groups of healthy young and old adults judged to have normal or near-normal vision. He found that the greatest performance differences were in the ability of the older subjects to see large objects and to detect moving targets. Such deficits might make it difficult to distinguish a figure from its background or to recognize a familiar face; it might even affect an older person's balance and coordination.

At the same time, Sekuler notes that the amount of contrast may help or hinder an older person's ability to discern objects. The eye chart test is generally done under optimal conditions of high contrast, while many routine activities are performed under low-contrast conditions (driving in fog or rain, for example). Since low-contrast conditions call upon an individual's ability to detect an object's gross features rather than small detail, this might place certain older persons at a disadvantage.

Although Sekuler and his colleagues speculate that the visual impairment they have observed may be a result of the normal aging process, they insist that their findings should not be used arbitrarily to define the capabilities—or limitations—of older people. With improved detection of any problems that occur, it may one day be possible to correct or prevent those problems.

Epidemiological Aspects of Aging Examined

The NIA has continued to strengthen its knowledge on the epidemiology, demography, and biometry of aging by adding funds to existing studies conducted by other agencies and organizations, as well as by conducting its own research.

The Institute has recently awarded contracts and reached important agreements on protocols for three major epidemiological studies on normal aging being conducted by investigators from Harvard University, Yale University, and the University of Iowa. Eleven thousand older people living in three communities are being interviewed to learn about basic processes of aging and the effect of social support systems on how they grow old.

Another study on mortality by birth cohort (people grouped by birth date; in this case, in 5-year periods) has shown that heart disease death rates for females have been dropping since at least 1940. The male heart disease mortality rate began to show a pronounced downturn in the period between 1960 and 1965, but male death rates remain higher than those of women.

A special arrangement between the NIA, the Census Bureau, and the National Center for Health Statistics is providing a more detailed age breakdown on the Census and other national surveys. Previously, all respondents aged 65 and over were grouped together. Now, data are being gathered by 5-year groups (65 to 69, 70 to 74, 75 to 79, etc.) to obtain more precise information about the elderly.

FUNDS FOR PROGRAMS ON AGING

[In thousands of dollars]

	1978	1979	1980	1981 estimate
Public Health Service:				
National Institutes of Health:				
National Institute on Aging	$35,057	$56,472	$69,725	$76,091

NATIONAL INSTITUTE OF ARTHRITIS, METABOLISM, AND DIGESTIVE DISEASES

The programs of the National Institute of Arthritis, Metabolism, and Digestive Diseases encompass a wide range of common and important chronic diseases, affecting millions of Americans of all ages. Of particular significance to persons over age 65 are NIAMDD's research activities involving arthritis, particularly osteoarthritis and osteoporosis; maturity-onset diabetes; benign prostatic hyperplasia, and nutrition as well as education and community demonstrations primarily associated with the Institute's Multipurpose Arthritis Centers and Diabetes Research and Training Centers.

Because research activities which specifically address the aging problem are assigned to the National Institute on Aging, NIAMDD has few projects in this category. They are:

Project No.	Project title	Fiscal year 1980 amount
5 R01 AM 20978-03	Aging and insulin effects on cyclic amp metabolism	$57,776
5 R01 AM 13710-11	Metabolism of testosterone (androgens) in man	49,717
5 R01 AM 21190-02	Lifestyles and bone densities of the aged	122,029
1 R01 AM 28176-01	Age and liver adrenergic receptor systems	76,157
	Total	305,679

As the U.S. population ages, the number of people at risk for the chronic, disabling diseases studied with NIAMDD support is expected to increase sharply. NIAMDD is committed to fostering fundamental and clinical research toward improving the Nation's means of coping with these diseases.

NATIONAL CANCER INSTITUTE

While the primary focus of research supported through the National Cancer Institute does not deal specifically with aging or the elderly, this area is an integral part of the study of cancer. It is thought, for instance, that the aging and carcinogenic processes may be directly related. Cancer, moreover, can occur at any age, but some cancers seem to strike particularly heavily at certain age groups. The study of certain cancers, therefore, may result in particular interest in the over-65 age group.

Investigation of the relationship between aging and cancer, as well as the study of cancers of the elderly is, like all biomedical research, a slow and painstaking process and does not change dramatically from year to year.

NATIONAL ORGAN SITE PROGRAM

The National Organ Site Programs Branch consists of grant supported national projects of targeted cancer research, each project oriented toward cancer at a specific organ site. Currently there are national organ site projects concerned with cancers of the urinary bladder, large bowel, pancreas, and prostate. Although the population affected by cancers at these organ sites is broadly based in terms of age, bladder and prostatic cancer tend to be heavily associated with, but not limited to, the over 65 age group.

Data from the SEER program of the Epidemiology Branch, NCI, indicate that the median ages of men and women at the time of initial diagnosis of bladder cancer are 69 and 72 years, respectively. There are 24,100 new cases of bladder cancer in men and 9,300 new cases in women each year. The median survival after diagnosis is about 4 years. Research on bladder cancer is being carried out under the aegis of the national bladder cancer project (NBCP), one of the NCI organ site programs. Because bladder cancer is a chronic disease which extends over a long portion of a patient's life, as long as 15 years, it is important that basic and clinical research take into account the prolonged natural history of the disease.

A close and effective relationship between basic and clinical research workers is being fostered by the NBCP. An example of this cooperation, and of the beneficial result which it can produce, is the development and use of the drug *cis*-platinum in the treatment of advanced and metastatic bladder cancer. This compound was first tested for its efficacy in bladder cancer in an experimental animal test system developed through the NBCP. Persuaded by its effectiveness in this experimental system, the compound was tested through clinical trials, where it was shown to be effective in patients. The next step was more extensive clinical trials, and these are now being conducted by a collaborating group, Clinical Collaborative Group A (CCGA), of several institutions across the country, all working through the national bladder cancer project.

The organization of CCGA is based upon the concept that bladder cancer is a relatively slow progressive disease and that increased understanding of the progression for various subgroups of patients under treatment will contribute to improved therapy through improved diagnosis and the classification of patients. Consequently, a basic protocol of this group is a study of the natural history of bladder cancer in all patients admitted by the participating physicians.

A multidisciplinary research program has been developed by the NBCP to encourage collaboration and effective exchange of information between clinical and laboratory scientists engaged in studies related to bladder cancer. Studies are supported which seek: (1) To identify carcinogenic factors and develop methods for minimizing their effects; (2) to identify new high risk human populations; (3) to increase understanding of bladder carcinogenesis and find methods for interferring with this process; (4) to increase knowledge of the pathogenesis of bladder tumors and develop means for interrupting this sequence of events; (5) to develop improved methods of detection and diagnosis and to find better means for matching diagnosed patients with the most effective and specific treatment regimens; and (6) to identify better means for improving the quality of life as the post-treatment interval is extended.

Information derived from studies on bladder cancer carcinogensis is providing a basis for promising new approaches which are being pursued. The demonstration that carcinogenesis of the urinary bladder is a multistep process, opens many potentially important areas of research which in the future may provide information on which the prevention of bladder cancer can be based. Worthy research objectives relate to the development of a rapid test for bladder carcinogenesis based on markers of preneoplastic lesions, further improvements in methods for identifying known bladder carcinogens and their metabolites in urine, and further development of methods of testing in the urine or other body fluids for metabolites which have been related to bladder carcinogenesis.

The new information from laboratory studies as to the carcinogens involved in the etiology of bladder cancer has increased the need for epidemiologic studies on various population groups. In many instances, relating epidemiologic results to laboratory results increases the understanding of each. In the rapidly developing area of bladder carcinogenesis, the formats of some of the epidemiology studies include several case-control studies in which populations having high incidence of bladder cancer are compared with populations having low incidence of this disease.

It is important to determine the role of seeding from primary tumors in the reestablishment of superficial carcinoma away from the site of the primary tumor. The role of cytology in the proper management of spreading superficial carcinoma of the bladder is so essential that continued efforts are being made to develop automated procedures for the identification of populations of cancer cells shed in the urine. Attempts to isolate a tumor-associated antigen from cancer cells shed in the urine of bladder cancer patients has been encouraging. This would be a useful indicator of cancer, and support of this area is continuing.

At present, transurethral resection is suitable for removing small to moderate-sized, localized, superficial cancer lesions. When superficial lesions are numerous or large, this form of surgery is inadequate and cystectomy is carried out. There is a need to develop an intravesical or systemic treatment less destructive than cystectomy. Results to date with the drug thioTEPA injected into the bladder are encouraging, and other chemotherapeutic agents such as mitomycin are available and are being tried.

Carcinoma of the prostate is the second most common site of cancer in men, accounting for 17 percent of malignant tumors occurring in U.S. males. The prostate cancer-related death rate (15 deaths annually for every 100,000 U.S. males) has not changed significantly over the past 30 years. In 1979 an estimated 64,008 new cases of prostatic cancer were diagnosed and over 21,000 deaths of American men are expected from this disease. In spite of these figures, prostate cancer has been the subject of only limited clinical and laboratory research through the early 1970's. In response to the need for a comprehensive and coordinated research effort, the national prostatic cancer project (NPCP) was activated in 1973, with headquarters at Roswell Park Memorial Institute, in accordance with the objectives of the national organ site program. The project has developed a research program that encompasses the areas of etiology and prevention, detection and diagnosis, and treatment of prostatic cancer. The pursuit of targeted research through investigator-initiated efforts has resulted in application of a broad spectrum of experimental research disciplines to prostate cancer, as well as the development and evaluation of single and combination therapy modalities for local, regional, and metastatic disease.

The focal point toward which the efforts of the national prostatic cancer project are directed is the prevention and improved treatment of prostatic cancer. This objective is complemented by immediate project endeavors aimed at decreasing morbidity and increasing survival time of prostate cancer victims.

The widespread use of endocrine therapy for prostatic carcinoma dates back to its first introduction in the early 1940's and continues to result in objective and subjective responses in the majority of patients. However, since hormonal therapy was unable to cure metastatic disease, the desirability of studying drugs which may affect this type of cancer was recognized and led to the July 1973 initiation of the cooperative clinical trials program of the national prostatic cancer project. This was the first national clinical cooperative program on chemotherapy of prostate cancer with criteria of patient randomization and clinical response tailored to the biological characteristics, metastatic behavior, and age of patients with this disease. Beginning with randomized studies of the effects of single chemotherapeutic agents on patients who fail to respond or no longer respond to conventional treatment, the program has expanded to include clinical trials using both single agents and combinations of agents aimed at patients with metastatic disease who are stable after previous treatment or who are previously untreated. Trials have also been initiated to determine the efficacy of chemotherapy as adjuvants to surgery or definitive radiotherapy in patients with earlier stages of the disease. Finally, the national prostatic cancer project supports efforts in the treatment category that are directed toward the synthesis of compounds with specific prostate cytotoxicity. Agents with potential activity are screened in animal, cell, and organ culture test systems, which are useful in selection of those chemotherapeutic agents for use in phase I and II trials.

In the detection and diagnosis category, a major effort continues to be directed at developing and testing specific and sensitive immunochemical assays for prostatic acid phosphatase as diagnostic tools. Identification and development of other potentially useful biological markers are being tested. This work is supported by tissue and serum repositories which provide investigators ready access to cell cultures, tissue samples, and sera samples from men with normal, benign hypertrophic, and carcinomatous prostates.

The search for factors associated with prostate cancer and a better understanding of the nature and history of the disease continues. Ongoing and new projects in the etiology and prevention category are directed at further characterization of established animal tumor models and development of new animal models. Complementing these model systems are organ and cell culture studies of human prostate tissue. The relating of prostatic carcinoma specific antigens to immune mechanisms continues. To date, virologic studies of prostate cancer have shown that viral particles do not play a significant oncogenic role in human prostate cancer. Models of prostate cancer are being studied extensively for risk factors associated with the development of the disease, and epidemiologic studies are probing the relation of genealogic, dietary, occupational, socioeconomic, sexual, and medical factors to human prostate cancer.

DIVISION OF CANCER BIOLOGY AND DIAGNOSIS

Our research has been concerned primarily with studies of abnormal, accelerated aging phenomena in humans who have diseases characterized by inherited defects in mechanisms which repair damaged DNA. Since DNA is the important chemical of human chromosomes which directs the metabolism of the cells, it is crucially important that it be maintained in an undamaged condition. The principal organs we have been interested in are the skin and the central nervous system. One feature of sun-exposed aged skin in the elderly is the development of skin cancers. From our studies of the disease xeroderma pigmentosum (XP) we have learned a great deal about the role of DNA repair processes in the development of sunlight-induced skin cancers. We have also learned from studies of XP that DNA repair processes protect all normal human beings from premature death of nerve cells. These studies are shedding light on possible pathogenic mechanisms responsible for the premature death of neurons in certain degenerative disorders of the nervous system, e.g., Huntington's disease. It is possible that information gained from studies of these degenerative diseases of the nervous system may elucidate mechanisms involved in normal, as well as abnormal, aging of the human brain.

There follows below an introduction to these topics from relevant publications: (Robbins, J. H. and Moshell, A. N., Journal of Investigative Dermatology volume 73, pages 102–107, 1979) (references have been deleted):

"Xeroderma pigmentosum (XP) is an autosomal recessive disease in which patients exposed to small amounts of sunlight rapidly manifest skin changes resembling the chronic solar damage that occurs in normal persons who have received excessive sun exposure over many years. Such cutaneous damage comprises degenerative changes including atrophy of the epidermis; 'solar degeneration' of the dermis; and development of pigmentation abnormalities, telangiectases, actinic keratoses, and cutaneous malignancies. The primary pathogenetic abnormalities in XP are inherited defects in DNA repair mechanisms. Even though individuals without XP do not have such inherited defects, it seems highly probable that at least some of the chronic solar damage to their skin develops through physicochemical pathways similar to, if not identical with, those producing the damage in the skin of XP patients. Thus information obtained from studies on XP patients and their cells may elucidate mechanisms resulting in solar damage in normal persons.

"One aspect of the definition of 'aging' expounded by Montagna and Parakkal is especially pertinent to the premature development of chronic solar damage in XP patients. ' "Aging" may mean either growing old or maturation. Since (in the former context) the word usually connotes loss of function, so-called age changes often apply to degenerative alterations rather than to those that are an integral part of the normal development of tissues. In this discussion, age changes encompass all of these, from embryonic life through senescence.' In light of this definition, the premature solar skin degeneration in XP patients can properly be referred to as an abnormal aging of the skin. Similarly, the premature death of neurons that results in the neurological abnormalities present in certain XP patients is also properly considered an abnormal aging process. The abnormal aging of XP skin and of the XP central nervous system is the result of inherited defects in the patients' DNA repair processes. However, since XP patients differ relevantly from other human beings only by virtue of their homozygosity for certain mutations in genes controlling DNA repair processes, we can conclude that certain levels of the functional capacity of these gene loci are required for the prevention in all normal human beings of the premature aging that occurs in XP patients."

FIELD STUDIES AND STATISTICS PROGRAM

The field studies and statistics program supports epidemiologic research designated to generate and test ideas concerning the origins of cancer by studying environmental and genetic factors that contribute to the occurrence of the disease. Studies attempt to identify groups of persons at high risk of cancer and test hypotheses that relate to specific risk factors. Data are collected and analyzed on cancer incidence by geographic location, race, age, economic status, and occupation. These studies are not primarily geared toward aging; however, they have shown that the incidence of cancer rises sharply with age. Analysis is made of age curves for the various cancer sites to provide precise information on how the risk of cancer varies with advancing age. The surveillance, epidemiology and end results program (SEER), covering approximately 10 percent of the U.S. population, has produced data that shows more than one-half of the cancers occur among persons 65 years of age and older. A monograph on cancer incidence and mortality in the United States from 1973 to 1977 will be produced in fiscal year 1981. This monograph will contain detail on specific cancers by geographic location, sex, race, and age. In addition, a number of publications on cancer of specific sites will be published covering the above variables as well as data on the problems of survival among those diagnosed as having cancer.

Through case-control and cohort studies we are attempting to determine what age groups are especially vulnerable to carcinogenic hazards, including chemical agents and ionizing radiation and gain a better understanding of the mechanism involved in carcinogenesis and how the aging process may increase the risk of cancer to those exposed to known carcinogens.

Several studies are being conducted to evaluate the relationship between menopausal estrogens and various cancers. There is conclusive evidence that the incidence of endometrial cancer is greater among women between the ages of 55 and 70 who have taken post-menopausal estrogens, and suggestive evidence that the risk of breast cancer is also increased in this group.

To clarify the mechanisms responsible for the link between cancer and aging, the Branch undertakes studies of population groups with conspicuous defects that may be more subtly associated with the aging process. For example, immune defects are seen with advancing age, and groups with pronounced immunodeficiency (e.g., genetic syndromes, kidney transplants) are prone to some neoplasms, notably lymphoma, but not all cancer across-the-board as might be expected on the basis of the immunosurveillance theory of cancer.

CANCER CONTROL

Within the context of the cancer control mission of the National Cancer Institute (NCI), the Division of Resources, Centers, and Community Activities (DRCCA) is proceeding with an initiative begun in 1979 which focuses on the impact of old age on cancer patient management. The effort has been broadened to include early detection and diagnostic issues as well. NCI wishes to determine whether there are special problems related to prevention or treatment of cancer in the older population.

DRCCA plans to convene a group of knowledgable experts from the fields of cancer prevention, cancer treatment, geriatrics and related professions and disciplines to determine whether there are problems and needs unique to the elderly which must be considered in order to facilitate prevention, detection, diagnosis, or treatment in this segment of the population. A working conference is being organized, in consultation with the National Institute on Aging (NIA), for September 1981. A planning committee has been formed and the first meeting has been held to specify the goals of the conference, identify participants, and delineate the areas in cancer and aging which should be addressed. It is anticipated that approximately 60–70 persons will meet to identify problems in cancer prevention and treatment that are unique to the elderly.

DIVISION OF CANCER TREATMENT

The Division of Cancer Treatment sponsors research which encompasses all aspects of the treatment of cancer. The majority of the research protocols include patients across the age spectrum and patients over age 65 are not separated for special treatment. However, in selected situations patients over age 65 have been the focus of a specific research interest and these will be discussed.

The investigators in the Eastern Cooperative Oncology Group have addressed the question of whether elderly patients experience more frequent or more severe side effects from anticancer treatment. They compared patients under age 65 with patients over age 65 who had received the same chemotherapy program. Older patients did not experience more frequent or more severe side effects compared with younger patients. This observation supports the philosophy of including patients in treatment protocols without regard to age if they satisfy other criteria for receiving the specific treatment.

In some diseases patients over age 65 have a poorer prognosis than younger patients. As an example, the Brain Tumor Study Group has documented that patients with malignant brain tumors who are over age 65 have a shorter survival than younger patients. The group has noted improvement in survival with administration of radiation therapy and chemotherapy but the negative effects of age persist even in the improved results. This is receiving continuing attention by this group.

In a few diseases older patients may respond differently to therapy than younger patients. An example is breast cancer where older patients have a more favorable response to hormone therapy than do younger patients. Three studies currently in progress demonstrate efforts to capitalize on this principle.

The Eastern Cooperative Oncology Group (ECOG) activated protocol 1.178 in April 1978. It is a randomized study comparing the antiestrogen, tamoxifen, to placebo in the surgical adjuvant therapy of patients with lymph node positive breast cancer who are 65 years of age or older. As of November 1980 a total of 97 patients had been entered on this study, 87 of them evaluable at the time of the update. So far, only four patients have relapsed. The study has not been followed long enough to permit conclusions. The Group continues to enter patients into the study.

Dr. Gianni Bonadonna in Milan, Italy, under contract with the Division of Cancer Treatment, is conducting a study in women over age 65 who have undergone mastectomy for breast cancer and who have involved axillary lymph nodes. The randomized trial compares combination chemotherapy consisting of cyclophosphamide, methotrexate, and 5-fluorouracil (CMF) with CMF plus the antiestrogen tamoxifen. The study is continuing to accrue patients. Again, the followup is too short to allow meaningful analysis of treatment results.

The ECOG also has a trial in women over the age of 65 with advanced, surgically unresectable breast cancer. This randomized trial compares hormonal therapy (tamoxifen) with the CMF combination previously referred to. At relapse patients are treated with the alternate therapy. As of June 1980, 161 patients have entered this study. There were no significant differences between the two treatments with respect to percentage of patients showing tumor regression, proportion relapsing, or duration of survival. This study continues to accrue patients.

In conclusion, there are important similarities and important differences between older and younger patients. Where differences exist an effort is made to capitalize on this for the patients' advantage.

We estimate that 15 percent of all nonpediatric research support goes to patients over age 65. The two ECOG breast protocols alone represent 3 percent of ECOG activity.

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE

In fiscal year 1980, the NHLBI supported 19 projects specifically related to aging, including 6 grants to study systolic hypertension in the elderly at a funding level of $1,855,712. The NHLBI also supports a very large program of research on arteriosclerosis, much of which relates to the elderly population. In fiscal year 1980, this program included over 350 projects and a total funding level of $91,861,000. Ninety-six of these projects had some direct relationship to the aging population, and were supported by $15,798,000.

NHLBI PROGRAMS ON AGING

Project No.	Project title	Fiscal year 1980 amount
1R01HL23913-01	Systolic hypertension in the elderly (human)	$285, 271
1R01HL23917-01	do	270, 063
1R01HL23919-01	do	410, 419
1R01HL23914-01	do	[1] 226, 639
1R01HL23916-01	do	[1] 291, 999
1R01HL23924-01	do	[1] 263, 610
5R01HL06736-20	Biogenic-mechanical factors in microcirculation (rats, gerbils)	137, 953
5R01HL10018-12	Effect of aging on beating heart cells in culture (rats)	71, 375
5R01HL17865-06	Studies on aging—Effects of sex hormones (rats, dogs)	104, 798
5R01HL18284-06	Aging erythrocytes—bio-recognition and elimination (monkeys)	67, 065
2R01HL18629-06	Influence of aging and hypertension on the myocardium (rats)	54, 063
5R01HL20546-03	Chemical analysis of human arterial lastin	32, 410
5R23HL21393-03	Cardiac adaptation to aging and stress (rats)	36, 772
5R01HL22313-03	Lung elastic recoil—age and disease (human)	14, 099
5R01HL23353-02	Age related changes in cardiac autonomic interactions (dogs, rabbits, mice).	138, 153
5R01HL24138-02	Prostaglandin synthesis and function in adult cardiac cells (rats)	48, 960
5R01HL23399-02	Cerebrovascular changes in age and hypertension (rats)	33, 052
5R01HL25408-02	Plasma activators of human pancreatic proelastase 2 (dogs)	36, 495
1R01HL25786-01	Quality of life and health status of former athletes	34, 764
	Total	1, 855, 712

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[1] Funded by the National Institute on Aging.

OFFICE OF THE INSPECTOR GENERAL

The mission of the Inspector General is to prevent and detect fraud and abuse in the Department of Health and Human Services (HHS) programs and to promote economy and efficiency in its operations. It is the Inspector General's responsibility to report to the Secretary and to the Congress any deficiencies or problems related to HHS programs and to recommend corrective actions.

The HHS Inspector General's Office is the first statutory position of its kind established in the Federal civil government. It was created by Public Law 94-505, enacted on October 15, 1976, and was the result of a congressional initiative, inspired at least in part by disclosures of fraud, abuse, or waste in Federal/State medical and welfare programs. The legislation places equal emphasis on the Inspector General's obligation to prevent or detect wrongdoing and his obligation to make recommendations for program improvements in HHS.

A basic philosophy of the Office of Inspector General (OIG) is to work in a coordinative and cooperative way with other organizations to accomplish its mission except when such a relationship would compromise the OIG independence. Close working relationships have been with the Health Care Financing Administration (HCFA), the Social Security Administration (SSA), and other major components of the Department in order to maximize resources devoted to common problems.

The Inspector General's Office is organized as follows:

The Assistant Inspector General for Auditing directs the HHS OIG Audit Agency which prepares or reviews more than 5,000 audits of HHS and its contractors and grantees annually.

The Assistant Inspector General for Investigations directs a staff that investigates activity of a potentially criminal nature against HHS programs.

The Division of Special Assignments is comprised of attorney/investigators (experienced prosecutors) and senior criminal investigators augmented by investigators from the Office of Investigations (OI) and auditors from the Audit Agency.

The Division of State Fraud Control has a primary responsibility of working with the States to improve the detection and elimination of fraud against HHS programs and is the OIG manager of the State medicaid fraud control unit (SMFCU) program.

The Assistant Inspector General for Health Care and Systems Review directs a small staff of senior analysts with specialized experience across the range of HHS activities. This office also manages the Service Delivery Assessment (SDA) staff function for the Secretary.

The Executive Assistant Inspector General is responsible for management and legislative functions of the Office of the Inspector General.

The Audit Agency and Office of Investigations have regional and branch offices. Each has 10 regional offices. The Audit Agency has 51 branch offices and OI has 18 branch offices.

The OIG has a number of projects which have an impact on the programs for the aging. A few are listed:

Home health agencies.—During the last 1½ years, the OIG has been conducting indepth investigations into home health management organizations in Florida. While the results of those investigations are not complete, we have identified some problems where corrective action should be considered. The inherent problems that need correction are:

(1) Startup and contractual arrangements, including consultant costs, fees for accounting and computer services, and management agreements.

(2) Salaries and fringe benefits; and

(3) Patient solicitation.

Reimbursement of hospital-based physicians.—Hospital-based physicians practice in a hospital setting and are compensated by or through the hospital. We reviewed the adequacy of medicare controls to ensure that payments to such physicians were reasonable. The result of our review at 61 hospitals in Oklahoma and Louisiana indicated that compensation received by such physicians may not be reasonable. Specifically, we found that:

—There were extreme variations in the amounts paid such physicians at hospitals of similar size, type and location.

—The compensation paid such physicians has dramatically increased over the last few years. Example: pathologists' compensation increased as much as 102 percent.

We concluded that the medicare program does not have procedures in effect to control the reasonableness of payments for services of such physicians.

Continuing attention is required to complete current plans to (1) completely revise the hospital based physicians regulations concerning compensation, and (2) provide simplified and mandatory guidelines for allocation agreements to assure uniform application of the regulations on a national basis.

End stage renal disease.—Ratesetting has not been done on the basis of audited costs. Recent audits have shown unaudited costs are not usable for this purpose. Additionally, early activities by OIG components show that there is no system established to review claims on a national basis to control fraud and abuse. The rapid growth of costs in this program (that treats relatively few individuals) indicates that administrative changes are necessary to control Federal expenditures.

Durable medical equipment project.—This project is under development and involves charges to Medicare for DME for extended periods after the patient has died or recovered. It is projected that the potential loss to the program is in the hundreds of thousands of dollars.

Project 90+.—This is a pilot project in Illinois which involves a computer match of vital statistics death tapes against SSA beneficiaries who are over 90 years of age. A preliminary manual match disclosed potential losses through payments to persons long ago deceased to be in the hundreds of thousands of dollars. If the pilot project is successful, it would be utilized in selected additional states.

Reimbursement of physicians in teaching hospitals.—Despite a 1972 law, regulations have never been issued. Presently no basis exists under administrative law to control abuse or fraud under medicare by teaching physicians who bill for services performed by interns and residents when these house staff are not truly supervised. Clear criteria are lacking as to what is a reimbursable service. This has prevented successful investigations leading to prosecutions.

OFFICE OF THE GENERAL COUNSEL

SIGNIFICANT HHS LITIGATION DURING 1980 AFFECTING THE ELDERLY

A. BUSINESS AND ADMINISTRATIVE LAW

1. *Thomas H. Casey* v. *Secretary of HEW* (4th Cir. 1979).—The Government's oral argument in this case was presented in the Fourth Circuit on December 4, 1979. The appeal arose from a dismissal of a former Black Lung Administrative Law Judge's Age Discrimination in Employment Act (29 U.S.C. §633a) claim that the nonrenewal of his term appointment at age 72 was discriminatory. The District Court had held that as the plaintiff was beyond the statute's upper limit, he failed to state a claim. There was no appeal from the transfer to the Court of Claims of the plaintiff's due process claim that he allegedly was not renewed because he was "too solicitous" of claimants' rights.

B. HEALTH CARE FINANCING ADMINISTRATION

1. *Caldwell* v. *Blum*, 621 F.2d 491 (2nd Cir. 1980).—This action was brought by and on behalf of aged, disabled or blind New York residents, challenging New York transfer of assets restrictions. Those restrictions provided that a voluntary transfer of assets in order to qualify for or maintain eligibility for beneficiaries rendered a "medically needy" person ineligible for medicaid benefits. The district court granted a preliminary injunction restraining enforcement of the New York statute, and the New York Department of Social Services appealed.

The Court of Appeals affirmed the district court decision, holding that New York's eligibility requirements were inconsistent with the applicable provision of the Social Security Act, 42 U.S.C. § 1396a(a)(10)(C)(i). Under that provision, a "categorically needy" applicant for supplementary security (SSI) benefits could by disposing of his assets become eligible for medicaid benefits. The court ruled that the State could not impose more restrictive eligibility requirements on the "medically needy" than what was provided for the "categorically needy" under the Social Security Act Section 5 of Public Law 96-611, a recent amendment to 42 U.S.C. §1696a enacted subsequent to *Caldwell*, may substantially affect the impact of this decision).

2. *Gray Panthers* v. *Administrator, Health Care Financing Administration, Department of Health and Human Services, et al.*, 629 F.2d 180 (D.C. Cir. 1980).—In this case, the Gray Panthers Organization challenged the validity of regulations of the Department of Health and Human Services implementing the medicaid program. The district court decision, holding the regulations invalid, was affirmed on appeal.

In its decision, the Court of Appeals held that the Secretary failed to take relevant factors into account in promulgating the medicaid regulations, which applied in nonsupplemental security income States and which permitted a certain amount of a noninstitutionalized spouse's funds to be "deemed" available for use by the institutionalized spouse. The court suggested that the Secretary consider the following factors: (1) The expectation that spouses should support each other; (2) that the statute provides for differing determinations of availability of income to be made under certain differing circumstances; (3) the deterrence of fraud and abuse; (4) the extent to which the assumption that spouses who maintain a common household will share income and expenses and constitute a single economic unit is undermined by the separation of the spouses by institutionalization; (5) the impact of deeming on the family under these circumstances; (6) whether the spouses were living apart before their separation by institutionalization; and (7) if they were living apart before institutionalization, whether support payments were being made on a regular basis from one spouse to another.

The Department has filed a petition for certiorari before the Supreme Court in this matter.

3. *Himmler* v. *Califano*, 611 F.2d 137 (6th Cir. 1979).—Plaintiffs brought a class action in this case challenging Department regulations. Under the regulations, a fiscal intermediary could decide to initially reject medicare payment for those services it deemed not "medically necessary" when such services had previously been certified as necessary by the beneficiary's physician and by a utilization review committee.

The Court of Appeals, reversing the district court decision, ruled for the Department, holding that the regulatory scheme at issue violated neither the Social Security Act nor the due process clause of the fifth amendment.

4. *Monmouth Medicare Center, et al.* v. *Harris* (D.C. N.J. 1980).—In this decision, the District Court of New Jersey held that the medicare program could not be required to subsidize periods of custodial care for hospital patients who were awaiting placement in medicaid intermediate care facility (ICF) beds. Plaintiffs have subsequently moved to amend their complaint with regard to seven beneficiaries whom, they assert, were receiving skilled services while awaiting placement in ICF's (In 1978, Administrative Law Judges had concluded that each of the named beneficiaries were receiving custodial care).

5. *Norman* v. *St. Clair*, 610 F.2d 1228 (5th Cir. 1980).—Plaintiffs in this case challenged Mississippi's practice of "deeming" the income of one spouse available to the other spouse for determining medicaid eligibility and "medicaid income," both where the spouses lived together and where one spouse was institutionalized. The district court had struck down "deeming" where the spouses were separated and permitted it where the spouses lived together with the limitation that only income in excess of those expenses necessary for the noneligible spouse to live in the community could be deemed.

On appeal, the Fifth Circuit Court of Appeals, after a lengthy analysis of the statutory language and legislative history, held that "deeming" of income of one spouse to the other for medicaid purposes, both where the spouses live together and where one spouse is institutionalized, does not conflict with the medicaid statute or the constitution. The court also held the state in the formulation of its applicable standards could not act arbitrarily or inflexibly, but must in determining the amount of protected income use a realistic and reasonable estimate of expenses necessary for the fulfillment of the spouse's basic living needs. Eleven district courts which had considered the issue had all invalidated deeming, but the Fifth Circuit declined to adopt their rationale. The Fifth Circuit also held that the State's treatment of the income of dependent children of medicaid applicants did not constitute "deeming" and that the State's inclusion of one spouse's old age, survivors and disability insurance in calculating the other spouse's eligibility for medicaid was not an unlawful garnishment.

6. *O'Bannon, Secretary of Public Welfare of Pennsylvania* v. *Town Court Nursing Center*, 100 S. Ct. 2467 (1980).—This case involved the issue of whether patients in a nursing home are deprived of due process when they are not given notice and opportunity to be heard prior to decertification, for purposes of medicaid payments, of a particular nursing home in which they reside. The Third Circuit Court of Appeals had held such notice and hearing to be constitutionally mandated. The United States Supreme Court, however, reversed and held the patients to enjoy no such rights

The Supreme Court held that medicaid patients have no interest in receiving benefits for care in a particular facility that would entitle them, as a matter of constitutional law, to a hearing before the Department of Health and Human Services and the State agency can decertify the facility. The Court reasoned that the Government may decertify a facility, even if such action results in the transfer of patients. Simply stated, the patients were not subjected to a withdrawal of direct benefits, despite the immediate adverse impact suffered by some patients as a result of the decertification. The Court concluded that such impact is merely indirect and incidental, and does not amount to a deprivation of any interest in life, liberty or property.

7. *Starnes* v. *Harris* (D.S.C. 1980).—Medicare beneficiaries and suppliers of CT scan services have brought suit against the Secretary and medicare part B carriers in North Carolina, South Carolina, and Georgia seeking declaratory and injunctive relief from the "cap" on the allowable charge for CT head scans suggested to carriers by part A/part B Intermediary 78–38 and currently in effect nationwide. Plaintiffs allege that the "cap" was imposed by the Department acting outside the scope of its authority and contrary to the "reasonable charge" methodology mandated by 42 C.F.R. 1395u and 42 C.F.R. 405.502. Plaintiffs further allege that, even if the Department had authority to impose a "cap," that authority could only be exercised through issuance of regulations and not through an intermediary letter.

The Department filed, on December 18, 1979, a memorandum opposing the injunctive relief being sought by plaintiffs. The Department argued that there was no likelihood plaintiffs would succeed on the merits because (1) the Court lacked subject matter jurisdiction to hear a medicare part B reimbursement dispute, (2) the reimbursement limits adopted by the carriers are consistent with the medicare act and implementing regulations, (3) the reimbursement limits were not imposed by HCFA in violation of the rulemaking requirements of the Administrative Procedure Act, (4) plaintiffs would not suffer irreparable harm if preliminary relief were not granted since there was no evidence that any plaintiff would either be denied medically necessary services or subject to undue financial hardship as a result of the cap, and (5) issuance of an injunction would harm the public interest in preventing needless and improper expenditures of medicare funds.

On March 7, 1980, the court granted plaintiffs motion and entered a preliminary injunction directing the Secretary to refrain from enforcing the challenged payment cap until further order or until regulations governing the imposition of cost limits currently under preparation are adopted.

8. *Williams* v. *St. Clair*, 610 F.2d 1244 (5th Cir. 1980).— Plaintiffs in this action challenged the medicaid policy of allowing institutionalized applicants to project medical expenses in determining their spend-down amount, but requiring noninstitutional persons to accrue actual expenses.

The Court of Appeals affirmed the district court and upheld the Department's position against both statutory and constitutional challenges. The court held that the Department could be more liberal with institutionalized persons because their expenses are more predictable and reliable whereas because of the possibility of fraud, abuse, and unreliability, the Department could require non-institutionalized persons to accrue actual expenses. The court ruled that such a distinction has a rational basis and furthered a legitimate State interest.

C. SOCIAL SECURITY ADMINISTRATION

1. *Chambers* v. *Harris* (D. N.M. 1980).—In this decision, the district court affirmed the Secretary's denial of a mother's insurance benefits to plaintiff because of the latter's failure to meet the marriage requirement of § 202(g) of the Social Security Act. Under that provision, a "widow" of a deceased wage earner who has his entitled child in her care may qualify for a mother's benefit. Plaintiff met all the requirements of the act, except that she was never married to the deceased wage earner. However, she argued that because she had lived with the deceased for a number of years prior to his death, under the 1976 California Supreme Court decision in *Marvin* v. *Marvin* she should be considered a "widow" for purposes of the Social Security Act. The court rejected this argument, stating that *Marvin* may be relevant for determining the proper disposition of property for interstate succession purposes, but did not grant plaintiff the status of "widow" for purposes of the pertinent Social Security Act provision.

Plaintiff has appealed the district court decision to the tenth circuit.

2. *Cockrum, et al.* v. *Harris* (D.C. Cir. 1980).—On September 15, 1980, the United States Court of Appeals for the District of Columbia Circuit stayed the adverse judgment entered by the district court and remanded the case to that court for it to consider dismissal when the time limits regulations submitted to the *Blankenship* district court are approved.

The *Cockrum* district court had earlier found that the processing of hearing requests under titles II and XVI was "unreasonably" delayed and ordered the Secretary to establish a plan for processing of hearing requests within a "reasonable" time. The court offered 120 days as a "benchmark" of that time period. The decision of the Court of Appeals deferred to the Sixth Circuit mandate in *Blankenship* v. *Secretary of HEW*, 587 F. 2d 329 (6th Cir. 1978), which required the Secretary to promulgate nationwide regulations for the processing of hearing requests within a "reasonable" time.

3. *Cook* v. *Harris*, 617 F. 2d 906 (2nd Cir. 1980).—In affirming the district court decision, the Court of Appeals in this decision held that where a wife's entitlement to social security benefits was derived from, rather than independent of, her husband's eligibility, it was not illogical that the benefits paid to both should be reduced when the husband's entitlement to full benefits was affected by his postretirement earning. Thus, the court concluded, section 203(b) of the Social Security Act, which reduced social security benefits due to postretirement earnings and charged part of such deduction against the benefit of the spouse of the retired wage earner, was not unconstitutional.

4. *Daisy Griffin, et al.* v. *Harris* (5th Cir. 1979.—The Fifth Circuit Court of Appeals has denied plaintiff's petitions for rehearing by the panel and rehearing

en banc. The court upheld the Secretary's policy of automatically offsetting supplemental security income gross "overpayments" against gross "underpayments" and applying the waiver of overpayment criteria to only *net* overpayments. *See* 20 C.F.R. §§ 416.537, 416.538. This class action suit had alleged that the Secretary could not offset a payment of more than the correct amount for one month against payments of less than the correct amount for a different month without first providing the recipient an opportunity for an administrative hearing.

5. *Jimmy Swain* v. *Harris* (M.D. Fla. 1979); *Arlene Weaver* v. *Harris* (M.D. Fla., 1979).—These cases were heard jointly by the magistrate, who reversed the Secretary in both cases. He stated that because the Florida statute in question provided for the offset of disability benefits against workmen's compensation benefits, the Secretary of Health, Education, and Welfare could not offset the workmen's compensation benefits against disability even though the Florida statute did not apply this offset to retroactive social security benefits.

Citing *Tarver* v. *Califano*, (M.D. Fla. No. 76-969) and interpreting § 224(d) of the Social Security Act, the District Court affirmed. The Department thereupon filed a Rule 59 motion, bringing to the court's attention the case of *Durrance* v. *Califano*, (S.D. Fla. 1978), wherein the court held that if Florida chose not to offset disability benefits against workmen's compensation benefits even though they had offset provisions in their statutes, the Secretary could apply the offset by workmen's compensation against disability. The court's reasoning was that Congress intended to "prevent the payment of excessive combined benefits" in response to "the concern that has been expressed by many witnesses in the hearings about the payment of disability benefits concurrently with benefits payable under State workmen's compensation programs." S. Rept. 404, 89th Cong. and Admin. News p. 1943 at 2040. Therefore, the court concluded that if the State did not utilize the offset provisions, the Social Security Administration may do so.

6. *Morris* v. *Harris* (E.D. Mo. 1980).—The district court here entered judgment for the Secretary, sustaining the constitutionality of section 202(f)(1)(A) of the Social Security Act, which requires as a condition of eligibility for widower's insurance benefits that the widower has not remarried. The comparable provision for widow's benefits, section 202(e)(1)(A), provides a benefit if a widow "is not married."

After plaintiff's wife died, he entered a second marriage which ended in divorce. Plaintiff's subsequent application for widower's benefits on his first wife's account was denied because he had remarried. He argued that a similarly situated widow would be eligible, and that his denial thus violated equal protection principles. A reviewing magistrate approved of the statutory difference, finding that the legislative history for the provision of widow's benefits to a woman who "is not married" demonstrated a congressional concern to protect nonwage earning women whose second marriage terminates.

7. *Mozelle Clark* v. *Harris* (5th Cir. 1980).—Plaintiff in this action has contended that the Court should adopt a per se rule that all claimants are prejudiced unless they are represented by counsel at a disability benefits hearing before an administrative law judge. Further, she contended that the written notice she received informing her of her right to counsel was, in actuality, insufficient to inform her of that right. The Department's position is that whether a plaintiff receives a full and fair hearing depends upon the facts of each case: having counsel is not necessarily a prerequisite. In this case, plaintiff had sufficient intelligence to understand the nature of her right to counsel and voluntarily waived that right. In addition, the Department has maintained that the facts indicated that plaintiff, despite her lack of counsel, had received a full and fair hearing; therefore, there is no need to remand the case for another hearing.

8. *Schwingel* v. *Harris*, 631 F.2d 192 (2nd Cir. 1980).—In this case, the Second Circuit reversed a district court judgment affirming the Secretary's determination that plaintiff had been overpaid SSI benefits and that waiver of recovery was not available.

Plaintiff had been notified that, due to her excess resources, she was ineligible for SSI benefits and had accordingly been overpaid. This decision was reversed by the Administrative Law Judge (ALJ) on appeal, who found that plaintiff's "excess resources" (retroactive supplemental security income payments) were not countable. Since the ALJ concluded that plaintiff had not been overpaid he never reached the issue of waiver. The Appeals Council subsequently reviewed the ALJ's decision and notified plaintiff that she could submit additional evidence on the matter within 20 days and could request oral argument. Plaintiff submitted an affidavit after the close of the 20-day period. The Appeals Council reversed the ALJ's finding on the overpayment issue and based on the record before the ALJ (but not plaintiff's affidavit), determined that waiver was not available, since plaintiff was "at fault in receiving the overpayment." The Court of Appeals held that since plaintiff's credibility was relevant to a finding of fault, she was entitled to a determination on that issue by an agency official who had heard her testimony. It also held that the Appeals Council's decision on this issue, without the benefit of plaintiff's testimony, deprived her of her right to a fair hearing as required by the act. The court remanded the case for further administrative proceedings.

9. *Stallings* v. *Harris*, 493 F. Supp. 956 (W.D. Tenn. 1980).—The district court here, on July 10, 1980, affirmed the Secretary's decision denying the claimant's application for disability benefits and upheld the constitutionality of the vocational factors "grid" regulations which became effective on February 26, 1979. The court also ruled that these regulations should be applied retroactively to claims brought before their effective date.

The district court decision has been appealed and currently is pending before the Court of Appeals for the Sixth Circuit.

ITEM 7. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

JANUARY 30, 1981.

DEAR MR. CHAIRMAN: Enclosed please find two copies of the Department's annual report to the Senate Special Committee on Aging—1980 highlights. The report is intended for inclusion in the committee's annual report, "Developments in Aging," and was to have been submitted by January 15, 1981.

The report was prepared under the supervision of former Secretary Landrieu's staff. If we can be of any further assistance, please let me know.

Very sincerely yours,

SAMUEL R. PIERCE, Jr.

Enclosure.

ANNUAL REPORT TO THE SENATE SPECIAL COMMITTEE ON AGING—1980 HIGHLIGHTS

I. OFFICE OF HOUSING

A. Office of Special Assistant for Elderly Housing

The Office was established on January 30, 1980, by the Secretary; the Special Assistant was designated that date at a meeting in HUD with the Elderly Housing Coalition. Since that time the Office has conducted a number of activities.

The Office cooperated with the White House Conference on Aging, particularly in setting up, and participated actively in the Mini-White House Conference on Housing the Elderly. Other Mini-White House Conferences in which the Office played a role included the Conference on Long-Term Care, Energy and the Elderly, Interlinking the Generations, and Vision and the Aging. The Special Assistant participated actively in more than two dozen other conferences, workshops and institutes on aging during the year.

The Office also is producing a series of publications: a significant one is on the theme of shared housing and living arrangements utilizing existing housing occupied by single persons. A single directory of assisted elderly housing is being assembled with the help of the Office of Management Information. A booklet on retirement housing planning for individuals and another on energy conservation for the elderly are also planned.

B. Public Housing

Legislative Background.—Public Housing, under the United States Housing Act of 1937, as amended, has always included the elderly as eligible residents. It was only in 1956 that public housing especially designed for the elderly, with safety and security features, etc., was expressly authorized by the Congress.

Handicapped persons with low incomes are statutorily included as "elderly," though they need not meet the minimum age specification of 62 years for residents. Public housing agencies develop and operate the housing, financed through direct HUD loans and the sale of bonds and other obligations. The Federal Government assists with annual contributions to repay the PHA borrowings and operating subsidy to assure that low rents and adequate services are available.

In 1970, legislation was enacted encouraging PHA's to build congregate rental housing for the elderly and handicapped. Contracts for such housing are limited to 10 percent of contracts entered into in each fiscal year. Congregate housing is intended to help avoid premature or unnecessary institutionalization for frail, elderly, and handicapped persons. The term "congregate housing" generally refers to projects which have a central kitchen and dining facility and in which some or all of the dwelling units do not have full kitchens. The management then has the responsibility to see that meals and other certain housing-related supportive services are made available to the residents as necessary. This arrangement permits some of the conveniences and economies of communal living to be built into rental projects, and allows elderly and nonelderly handicapped persons to remain semi-independent through management provision of meals and supportive services. An example of this housing—Arthur King Manor—was completed by the Duluth (Minn.) Housing and Redevelopment Authority in 1980 and a second project is now being built. Occupants of King Manor are a mix of relatively independent and frail in need of meals and housekeeping and personal services, and people receiving board and lodging care (nonmedical, but around the clock). The services are funded in part through a grant under HUD's congregate housing services program, authorized by congressional legislation in 1978 and discussed elsewhere in this report.

Current Statistics.—In fiscal year 1980, a total of 15,223 public housing units was completed; 5,200 of these were for the elderly. Construction starts in 1980 totaled 36,365 units of which 10,561 were for the elderly. By comparison, a total of 44,372 units—both family and elderly housing—was completed in the previous fiscal year. Cumulatively, there are well over 1 million public housing units in the Nation, at least 44 percent of which have elderly residents. Housing for low-income elderly provided under section 8 legislation—rent certificates—is not included in the above figures. The percentage of total section 8 housing—especially new construction—for the elderly is considerable. (See discussion of section 8 that follows.)

C. Section 8

The section 8 program provides assistance to encourage the construction of new units, the moderate or substantial rehabilitation of units, and the use of standard existing units. It encourages the participation of both private developers and public housing agencies. And, importantly, section 8 can maximize the use of the existing housing stock, while inducing production of additional units in markets where the supply of existing housing is inadequate to meet the need.

The legislation requires that section 8 projects serve lower income and very low-income families. Further, some projects are developed with a mix of assisted families.

No family assisted under section 8 may pay more than 25 percent of its income for rent. The rental payment may be as low as 15 percent, however, depending on family income, size, and medical or other unusual expenses.

Several other features of the section 8 program are of special advantage to older Americans:

> Eligibility for section 8 assistance, like public housing, includes two or more unrelated elderly, disabled, or handicapped persons who are living together, or one or more such individuals living with another person who is essential to their care and well being.
>
> FHA multifamily mortgage insurance programs are available to both section 8 developers and nonprofit sponsors to provide the project financing for new construction or substantial rehabilitation. Public housing agencies may also finance construction or rehabilitation of section 8 assisted units by issuing tax-exempt obligations under section 11(b).

Assistance for congregate housing is available under the section 8 program.

In fiscal year 1980, the Department reserved 212,000 section 8 units, of which 73,000 or 34 percent were for elderly.

D. Indian Housing

The Office of Indian Housing administers HUD housing activity on Indian reservations. The following accomplishments on behalf of elderly occurred during 1980:

—Of the 4,893 Indian housing units reserved, 429, or approximately 9 percent, were designated for elderly Indians;

—Of the 4,163 Indian housing units reaching construction start, 469, or approximately 11 percent, were for elderly Indians; and

—Of the 5,379 Indian housing units made available for occupancy, 282, or approximately 5 percent, were for elderly Indians.

E. Section 202—Direct Loans for Housing for the Elderly or Handicapped

The section 202 program was first enacted as a part of the Housing Act of 1959 to provide direct Federal long-term loans for the construction of housing for the elderly or handicapped. The program was intended to serve elderly persons whose income was above public housing levels but still insufficient to secure adequate housing on the private market. The section 202 program was amended by the 1974 Housing and Community Development Act to change the method of determining the interest rate (which had been set at 3 percent statutory maximum in 1965) and to permit the use of section 8 housing assistance payments for projects constructed or substantially rehabilitated under the program. The interest rate applying to loans closed during the fiscal year ending September 30, 1980, was 9 percent during the construction period and 8½ percent during the 40-year amortization period. In fiscal year 1981, a single rate of 9¼ percent will be charged both during the construction period and the amortization period.

HUD has been authorized to lend up to $5 billion through fiscal year 1980. At the end of fiscal year 1980, 1,679 projects with nearly 116,000 units had received funds reservations for nearly $4 billion (unadjusted). This includes approximately $65 million which had been allocated in total over 3 years for a demonstration program for housing for the chronically mentally ill, including elderly persons, of which $25 million were allocated in fiscal year 1980, the third year of the demonstration. Congregate housing is permitted under the section 202 program.

As of September 30, 1980, a cumulative total of 734 projects with over 69,000 units had been placed under construction since reactivation of the program. Of these, 247 projects with about 26,200 units already were completed. A total of $830.8 million, expected to finance the development of about 18,000 units, will be available for fund reservations for fiscal year 1981. Section 202 staff also continues to assist in the congregate housing services program.

F. Section 231—Mortgage Insurance for Elderly Housing

Under section 231 of the National Housing Act, as amended, the Department is authorized to insure lenders against losses on mortgages used for construction or rehabilitation of rental accommodations for older persons (aged 62 years or more, married or single).

Section 231 is HUD's principal program designed solely for unsubsidized rental housing for the elderly. Nonprofit as well as profit-motivated sponsors are eligible under the program, and section 8 housing assistance payments can be made available on competitive basis. Section 231 permits congregate housing projects to be built.

During fiscal year 1980 the Department insured 17 projects consisting of 1,641 units, bringing the total number of projects currently insured under the section 231 program to 490 projects consisting of 65,318 units.

G. Sections 221(d)(3) and 221(d)(4) of the National Housing Act—Mortgage Insurance Programs for Multifamily Housing

While these programs are not specifically for the elderly only, they are available to sponsors as alternatives to the section 231 program.

Sections 221(d)(3) and 221(d)(4) authorized the Department to provide insurance to finance the construction or rehabilitation of rental or cooperative structures. Special projects for the elderly are provided under these programs. A priority in occupancy is given to those displaced by urban renewal or other governmental action. (Because they tend to be residential occupants of older and deteriorating urban neighborhoods, a greater proportion of older persons than younger persons are affected.)

In fiscal year 1980, 887 projects containing 95,777 units were insured under these programs. Since their inception, these programs have insured 7,945 projects containing 865,151 units, of which about 7 percent are for the elderly.

H. Section 223(f) Mortgage Insurance for the Purpose of Refinancing Existing Multifamily Housing Projects

This program offers mortgage insurance for existing facilities, including housing for the elderly, where repair costs do not exceed 15 percent of project value. The program can be used either in connection with the purchase of a project, or for refinancing only. To the extent that real estate liquidity is enhanced, the availability of section 223(f) encourages investment in residential real estate of all kinds. Prior to its being added to the National Housing Act in August 1974, project mortgage insurance could be provided only for substantial rehabilitation or new construction.

I. Section 232—Mortgage Insurance for Nursing Homes/Intermediate Care Facilities

The primary objective of the section 232 program is to assist and promote the construction and rehabilitation of long-term care facilities. Since program enactment in 1959, the Department has insured mortgages for 1,291 facilities providing 147,632 beds.

Approximately 90 percent of the residents of nursing homes are elderly. HHS's medicare and medicaid programs have made it possible for many, who would not otherwise have been able to do so, to benefit from the services provided under this program.

Section 312 of the Housing and Community Development Amendments of 1978, Public Law 95–557, amends section 232 of the National Housing Act to allow space for day care for the elderly and others in nursing homes and intermediate care facilities with HUD-insured mortgages. The purpose of day care for the elderly and others is to provide protective care and offer social contracts with others, plus providing useful creative activities. Day care enables family members to work without having to worry about elderly or other infirm persons left alone at home all day. Additionally, day care is a cost-saving measure and can prevent premature or unnecessary institutionalization. Final regulations have been published and the program will be operational in the near future.

II. OFFICE OF NEIGHBORHOODS, VOLUNTARY ASSOCIATIONS AND CONSUMER PROTECTION

A. Human Services Division

The Human Services Division has, in addition to its other duties, responsibilities related specifically to the elderly. It participates in the development or provision of HUD policies, programs, and procedures affecting the elderly; coordinates HUD elderly initiatives and responses; and represents HUD in activities with other Federal, State, and municipal or private organizations relating to the elderly. The Division gives high priority to maintaining liaison with the Administration on Aging (AoA) and with national organizations for the elderly.

In this role, the division staff in the past year attended numerous meetings and conferences and participated in a number of other activities. Staff participated in the initial planning for the White House Miniconference on Housing for the Elderly and made presentations at the conference.

The division has continued work as the Department's representative on the Federal Council on Aging's Long-Term Care Committee, the AoA Task Force on Nutrition, and the Inter-agency Task Force on Information and Referral.

Congregate Housing Services Program

The Human Services Division has committed extensive effort to the continued development and implementation of the congregate housing services program (CHSP). The program authorizes HUD to extend multiyear grants (3 to 5 years) to eligible public housing authorities and nonprofit section 202 borrowers. The funds provide meals and other supportive services to frail elderly and nonelderly handicapped residents to assist them to remain independent. These services are intended to prevent or delay unnecessary or premature institutionalization of residents. The program ties services to housing in order to assure a more stable source of funds to housing management for the services needed by residents. Further, the funds give incentive to builders to produce needed congregate facilities.

All fiscal year 1979 moneys have been committed to grantees except for the $1 million legislatively required to be held back from each year's appropriation to cover the costs of inflation and other adjustments. Twenty-nine of these grants are in operation serving approximately 1,300 residents. Seven new construction projects will not be negotiated until initial occupancy (1981 or 1982).

Ten million dollars was available in fiscal year 1980 for grantees; of this amount, the $66 million allocated to existing projects was committed to grantees in September, 1980. These grants will be for 5 years. They will serve approximately 800 residents a year, and are now in the process of final contract negotiations. The grantees selected were chosen from among the total of 140 nominated by HUD's regional offices; of the 140 nominated, 56 actually applied for funds.

The $3 million of fiscal year 1980 funds reserved for new construction projects will be competitively announced in the near future.

All grantees offer a meal service as required by the act, though the pattern of meals varies, e.g., some offer lunch and dinner, while others offer breakfast and dinner. With few exceptions the grantees are also offering personal assistance and housekeeping/chore services. Many of the grantees are providing other services with transportation the next most popular offering.

During 1980, the evaluation of the CHSP was designed by HUD's Office of Policy Development and Research. A contract was awarded to the Hebrew Rehabilitation Center for the Aged in Boston in September and the contractor is now in the field collecting the first round of data. Some initial findings will be incorporated in HUD's second annual report to Congress which will be submitted early this winter. AoA, through an interagency agreement with HUD, is assisting in financing the evaluation.

B. Interstate Land Sales Registration

Congress passed the Interstate Land Sales Full Disclosure Act in 1968 to give the public a measure of protection against fraudulent and deceptive land sales operations. The act is administered through HUD's Office of Interstate Land Sales Registration. Although the act is intended to provide protection for all consumers, it is evident that a great number of potential victims of fraudulent land sales could be the elderly.

The property report is the key to the protection available to consumers under the act, since developers are required by law to give the prospective purchaser a property report prior to or at the time of signing a contract. The disclosure contained in a property report covers such items as the following: (1) Existence of mortgages, liens, and other encumbrances; (2) whether contract payments are set aside in a special (escrow) fund; (3) cost and availability of recreational facilities or of roads, water, and septic systems.

In the last few years allegations of overregulation by the land development industry and increased congressional interest resulted in extensive amendments to the act in December 1979. These amendments, which became effective in June 1980, created new exemptions from the act's registration requirements in certain cases where lack of disclosure to purchasers is deemed not to have an adverse effect.

The act's antifraud and antimisrepresentation provisions still apply to these sales programs. These recent amendments also extended the purchasers' cooling-off period from 3 to 7 days, added extensive new contract rights and expanded, both in scope and duration, purchasers' rights to sue developers in civil court for violations of the act. Revised regulations became effective on June 21, 1980, incorporating the amended legislation, and represent the product of 2 years' efforts toward simplifying procedures for developers while simultaneously providing readable disclosure information for purchasers and meaningful consumer protection.

C. Neighborhood Self-Help Development Program

The neighborhood self-help development grant program provides financial support of neighborhood development organizations to prepare, finance, and implement specific neighborhood revitalization projects. To be eligible, organizations must have a track record or demonstrable capacity for the proposed project and must be representative of and accountable to the neighborhood where the project is located. Almost any specific project related to a neighborhood revitalization strategy can be eligible provided the application meets certain requirements, including a certification from the chief elected official that the project is consistent with local plans. Grant funds support the costs of project preparation (e.g., architectural services, financial packaging, etc.) and a portion of the costs of project implementation. The balance of the costs of project implementation is derived from other public and private sources.

The program provides training and technical assistance to eligible neighborhood development organizations, HUD area office personnel, local units of government, and related public/private sector organizations in order to increase the success rate of neighborhood development organizations in planning, financing, managing, and evaluating neighborhood revitalization projects. This training and technical assistance includes workshops on program development and management skills in various parts of the country; onsite assistance to neighborhood organizations; publishing and distributing trainer and resource manuals; and establishing cooperative agreements with national organizations to undertake training workshops for their constituency groups and member organizations.

A program of information exchange and technology transfer has also been established to publicize successful neighborhood revitalization models which may assist neighborhood self-help groups in developing new projects. The program includes maintenance of a mailing list for national, regional, and local neighborhood organizations; the periodic publication of an ALERT newsletter on programs available to neighborhood self-help organizations; the nationwide operation of a neighborhood information sharing exchange which enables groups to share their knowledge and experience; and the development and dissemination of how-to and resource publications and audiovisuals.

In the first year of the program, operating with funding of $15 million, the Office made grant awards to 125 neighborhood organizations. Although most of these organizations are not generally elderly oriented, their activities can and often do include projects designed to meet the needs of elderly residents. For example, the International District Improvement Association in Seattle, Wash., is assisting elderly Chinese/American residents, many of whom have been farmers, to produce lower cost food. The Santa Barbara Community Housing Corp., in Santa Barbara, Calif., is managing the financing, construction, and development of neighborhood facilities associated with the construction of a housing cooperative for the elderly. Amigos Del Valle, in McAllen, Tex., is rehabilitating 40 low-income houses for the elderly utilizing the group's work crews. The Walnut Hills Redevelopment Foundation, in Cincinnati, Ohio, is preparing and packaging the construction of 100 units of elderly housing and implementing the adaptive reuse of an adjacent school for low-income housing and social service facilities.

Other activities of the program address the needs of elderly residents. Six workshops were given on neighborhood technologies for 720 participants from units of local government and neighborhood organizations. One technology discussed was the delivery of services to the elderly, incorporating them into neighborhood activities.

III. OFFICE OF POLICY DEVELOPMENT AND RESEARCH

Title V of the Housing and Urban Development Act of 1970 authorizes and directs the Secretary to undertake programs of research, studies, testing, and demonstrations relating to the mission and programs of the Department. Section 815 of the Housing and Community Development Act of 1974 strengthened the role of HUD research in the areas of elderly and handicapped by specifically encouraging demonstrations related to the housing problems of members of special user groups, including the elderly and handicapped.

The HUD research program serves as a stimulus for positive change in housing and urban conditions by conducting research and by demonstrating new methods for application of government and private expertise to the solution of housing problems. The program serves as a national focal point for housing and community development research and as a central point for research, analysis, and data collection and dissemination on these issues for the Department.

The focus on research related to the problem of the elderly and handicapped is in HUD's program of special user research, although other program areas such as community design research and economic affairs also support research which impacts on the elderly and handicapped.

The mission of the special user group research program is to design, conduct, and support research and demonstration projects whose results will improve housing conditions and related housing and community services for the elderly, the handicapped, and other members of identifiable special user groups.

A. Current Special User Research

The Office of Policy Development and Research has recently completed or is currently sponsoring several projects related to the housing problems of the elderly; work will continue in 1981. The following list demonstrates the scope of these recently completed and ongoing projects:

—Work continued on the design of a longitudinal study of the relationship between important changes which people experience as they grow older and various housing changes which they undertake. The national survey will be conducted annually for 10 years. Some of the housing activities to be investigated include alterations to the physical structure, routine maintenance, and shifting uses of rooms, as well as relocation to a different residence. Individuals selected for inclusion in the first year of the study will be followed during the subsequent years so that the data do not provide a one-sided picture of nonmovers.

—Another initiative, begun in 1978 and continued through 1980, was an evaluation of Baltimore's experimental home maintenance program. The program's objective is to help eligible households living within the target area with minor maintenance and repair problems which, if unattended, can lead to serious deterioration of individual properties as well as negative effects on neighborhood stability. Persons living in the area who are either 55 years of age or older, physically handicapped, or single parent householders are eligible for the program. Early evaluation results of this two-stage study form the basis for a multicity demonstration of the home maintenance and repair program concept.

—Design and development work are completed on the elderly home maintenance demonstration in 1980. Cofunding by several private foundations was secured and service delivery is now underway at all seven cities. Contracts were awarded for administrative support services and for evaluation of the demonstration. The evaluation design is being completed and baseline data are being gathered for the 2-year project.

—The Gerontological Society is developing a research agenda for HUD on issues related to the housing needs of the elderly. The agenda will guide our program over the next several years.

—A companion to the book "Low Rise Housing for the Older People" is being prepared and will focus on the special design problems of providing mid-rise and high-rise elevator buildings to meet the social needs of the elderly.

—A contract was awarded for the evaluation of the congregate housing services program which is being jointly sponsored by the Office of Housing and the Office of Neighborhoods, Voluntary Associations and Consumer Protection. P.D. & R. is working closely with evaluation staff from AoA, which is helping to sponsor the evaluation.

—A 6-month study of the housing needs of the elderly and handicapped in rural areas was completed. Required under the Housing and Community Development Amendments of 1979, this study looked at housing resources available through HUD as well as at the Farmers Home Administration.

—Several P.D. & R. publications reflect concern for the elderly: (1) "Occasional Papers in Housing and Community Affairs;—Volume I," "The Housing of Independent Elderly," (2) "Volume III: Housing Options for the Elderly," (3) "How Well Are We Housed? The Elderly," and (4) "Annual Housing Survey: 1973—Housing Characteristics of Older Americans in the United States."

Other Studies

The second major focus of the special user research program is on the handicapped; much of that research has major implications for the elderly.

—An evaluation of the demonstration for housing the chronically mentally ill, including the elderly, which is being conducted by the Office of Housing, is underway. Phase I, which examines the problems of implementing such a program, is nearing completion. Phase II, now being designed, will examine the costs and benefits of such housing.

—A cost study of the implications of section 504 for the retrofitting of public housing, combined with a similar analysis of the costs of retrofitting for energy conservation and modernization, is near completion.

—A major accomplishment has been the development of a new American National Standard on accessibility for the handicapped, published by the American National Standards Institute (ANSI). Although ANSI standards are voluntary, they gain the force of law by being referenced or included in State or local codes and Federal regulations. The ANSI project also resulted in the publication of eight volumes of research report which received a *Progressive Architecture* award in 1979.

—The construction of four out of six demonstration units being built in accordance to the new ANSI standard has been completed and those four units are occupied. The costs of each unit are being carefully compared with identical, but nonaccessible, units so that we can identify the true costs of accessibility. The units have been open to the public and their market acceptability is being evaluated.

Future Research

During fiscal year 1980, most of the special user budget will continue the longitudinal study, the Baltimore evaluation and the multicity demonstrations. If additional funds are available, one or two of the projects included in the new agendas will be started.

IV. OFFICE OF FAIR HOUSING AND EQUAL OPPORTUNITY

Congress passed the Age Discrimination Act of 1975 to prohibit discrimination on the basis of age in programs or activities receiving Federal financial assistance. The Department of Health and Human Services is the agency responsible for coordinating the governmentwide implementation of the Age Discrimination Act.

Under HHS's governmentwide implementation plan each Federal agency was asked to publish a proposed regulation defining Age Discrimination Act policies and procedures which apply to recipients of Federal financial assistance. HUD's proposed regulation defining Age Discrimination Act policies and procedures which apply to recipients of Federal financial assistance. HUD's proposed regulation was published in the Federal Register on November 4, 1980, with comments due by January 5, 1981.

HUD's annual training course in 1978 included training on the Age Discrimination Act. Brochures are provided to Age Discrimination Act complainants and recipients named in complaints alleging age discrimination that are received by the Department. Recently a public meeting was held with seven groups (which deal with the problems of the elderly and the young) explaining the proposed HUD regulations.

HUD has received approximately 20–25 complaints alleging age discrimination. The majority allege age discrimination in obtaining housing. On the age complaints received and referred to the Federal Mediation and Conciliation Service, approximately 15 have been successfully mediated.

V. COMMUNITY PLANNING AND DEVELOPMENT

A. Community Development and Block Grant (CDBG)

The community development block grant program is the major funding source for cities to conduct a wide range of community development programs. It is a $4 billion program, $3 billion of which goes to 650 cities and urban counties by entitlement, amounts determined by formula, and $1 billion goes to approximately 2,000 small cities (under 50,000 population) which compete through States and area offices. Block grants may be expanded to help low- and moderate-income households, to eliminate slums and blight and to meet urgent needs. The primary objective of the legislation is the development of viable urban communities by providing decent housing and a suitable living environment and expanding economic opportunities, principally for persons of low and moderate income.

Block grant applicants are required to develop housing assistance plans (HAP's). The distribution of housing assistance in these HAP's varies by the type of housing assistance planned by local communities. Thirty-three percent of the new construction planned by communities is targeted for elderly and handicapped households. This percentage of assistance would meet nearly 40 percent of the housing assistance goals for the elderly and handicapped in the fourth program year. Another 25 percent of their housing assistance goals would be met by rehabilitated housing and 20 percent by existing units.

CHART I

PERCENT OF TOTAL EXPENDITURE OF BLOCK GRANT FUNDS BY PERCENT OF ELDERLY CONCENTRATION BY NEIGHBORHOOD LOCATION, 1976, 1977, 1978, AND 1979

Neighborhood location	Elderly concentration												Total (percent)
	Low concentration (0 to 9 percent)				Medium concentration (10 to 19 percent)				High concentration (20 to 100 percent)				
	1976	1977	1978	1979	1976	1977	1978	1979	1976	1977	1978	1979	
Residential	38.2	39.6	33.8	37.5	54.6	53.6	53.6	54.9	7.3	6.8	8.6	7.5	100
Central business district	.7	2.6	7.6	13.2	28.7	22.3	23.5	39.7	70.6	75.1	68.9	47.1	100
Other commercial areas	29.1	33.9	26.6	33.3	60.8	56.2	60.2	52.0	12.5	9.9	13.3	9.6	100

Local plans for fiscal year 1978 called for 29 percent of their total housing assistance to be distributed among the elderly and handicapped. Elderly and handicapped households represented 33 percent of the total needy population.

A performance report for fiscal years 1975–77, based on a 147 cities sample-covering, shows that of housing for which a financial commitment was made, 52 percent of the units are to benefit the elderly and handicapped. In this same time period the elderly need was 33 percent of the total need for local housing assistance.

CHART II

PERCENT OF RESIDENTIAL EXPENDITURES ON CDBG FUNDED ACTIVITY BY PERCENT OF ELDERLY CONCENTRATION, 1976, 1977, 1978, AND 1979

CDBG funded activity	Elderly concentration												Total (percent)
	Low concentration (0 to 9 percent)				Medium concentration (10 to 19 percent)				High concentration (20 to 100 percent)				
	1976	1977	1978	1979	1976	1977	1978	1979	1976	1977	1978	1979	
Clearance related	33.2	42.5	35.1	37.1	59.1	48.4	48.8	52.1	7.8	9.2	16.1	10.2	100
Code enforcement	33.7	30.0	33.0	33.0	59.7	61.0	58.3	59.5	6.6	8.2	8.6	7.5	100
Housing rehabilitation loan grants	28.9	34.3	33.9	33.0	64.2	57.5	56.7	59.0	6.9	8.1	9.5	8.1	100
Services related	27.2	55.1	38.5	36.7	61.4	42.4	44.4	52.1	11.3	2.5	17.1	11.2	100
Public services	35.8	43.0	39.0	37.3	56.4	51.2	53.2	54.3	7.7	5.8	7.9	8.5	100

B. Urban Development Action Grants (UDAG)

The urban development action grant program provides grants to cities and urban counties which meet minimum standards of physical and economic distress. The purpose of the program is to improve the economic base of those cities and provide permanent jobs, especially for low- and moderate-income persons. The program seeks to attract private investment to distressed localities; no grants are approved unless there are firm commitments of private funds to carry out project development. Preliminary approvals of action grants are based upon nationwide competition on a series of factors including the relative distress of the city, how much private money is attracted by the UDAG grant, the number of jobs created, the seriousness of the economic problems of the locality and other factors. In 1979, a "pockets of poverty" provision was added to the program, permitting localities which are not distressed to apply for grants to assist areas of the city which have many low-income households.

Since 1978, 44 projects in 22 States and Puerto Rico, have been awarded funds which have as their only or a major purpose meeting needs of the elderly. The UDAG grants range in size from a $100,000 grant for a residential development in Pico Rivera, Calif., to a $7 million grant in Chicago.

Attached at the end of this report is a list of some of the projects approved during fiscal year 1980 which directly benefit elderly households.

C. Section 312

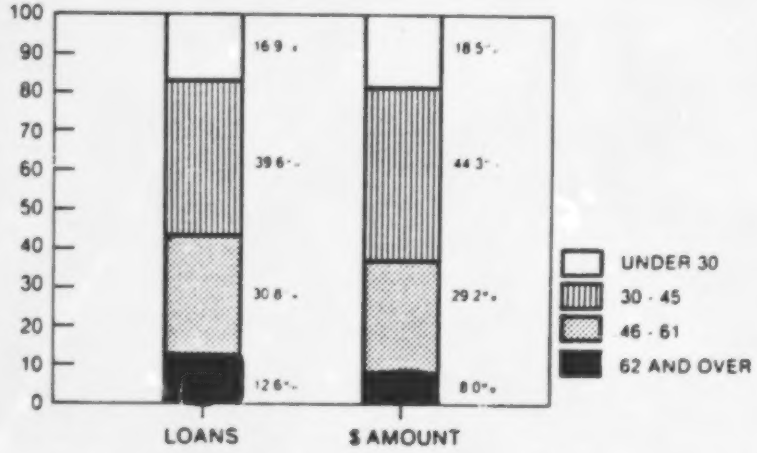
Section 312 loans are direct loans to owners, and sometimes tenants, of properties located in specific HUD assisted areas, the most common being community development block grant activities areas The localities and cities receiving HUD block grant assistance process loan applications in conformance with the law and the regulations. The Congress has directed that priority be given to low- and moderate-income occupants. Multifamily loans are required to be for structures: (1) In low- and moderate-income areas, or (2) with the majority of tenants having low or moderate incomes.

Loans may be made on most kinds of properties, where consistent with the locality's community or economic development strategy. The priorities for making loans have directed funds primarily to properties containing fully defined dwelling units. However, recent legislative amendments clarified the authority of localities to make loans to properties containing congregate housing dwelling units and to single room occupancy properties. Rehabilitation loans are made at low interest rates, 3, 6, or 9 percent, depending upon the family income for residential single family properties or upon the type of property for other loans. The term of the loan shall be the shortest reasonable term consistent with the borrower's ability to pay; but, in no instance more than 20 years.

In fiscal year 1979, 12.6 percent of section 312 rehabilitation loans were made to persons who were 62 years of age and older. These loans accounted for 8 percent of the total of funds available under section 312 for fiscal year 1979 (chart III). This probably indicates that elderly borrowers tend to use section 312 moneys to do basic repairs to their homes, rather than to undertake major rehabilitation projects.

CHART III

FY 1979 SECTION 312 LOAND AND LOAN FUNDS, BY AGE OF BORROWER
OWNER-OCCUPIED
(PERCENT)



Another indicator of benefit to the elderly from section 312 loans is that 56.5 percent of section 312 loans in fiscal year 1979 were made in census tracts where the proportion of residents who were retired was greater than the overall proportion of retired residents in the city. This is to say that section 312 is targeted to neighborhoods that have a relatively high proportion of elderly residents.

CHART IV

COMPARISON BETWEEN SEC. 312 TRACT LOCATIONS AND THE CITY AS A WHOLE—PERCENT RETIRED

Percent retired	Number of tracts	Percent of tracts
Greater than or equal to city	287	56.5
Less than city	221	43.5

D. Secretary's Discretionary Fund

Community Planning and Development administers the Secretary's discretionary fund for HUD, a fund of up to $104 million. Out of that fund, assistance can be obtained for technical assistance, innovative grants, Indian programs, and disasters. There are a number of programs being conducted by CPD that benefit elderly households, but those which are directly focused on elderly households are several of the innovative grants and at least one technical assistance program.

In 1979, a major innovative grant competition was held for communities to request funds for antidisplacement projects. Of the 12 which were selected, a number are either directed specifically at the elderly or have implication for elderly tenants. For example, in Brookline, Mass., and King County, Wash., the innovative grant is being used to help elderly and other low-income renters stay in apartments converting to condominiums, and in Denver, Colo., to convert a surplus school into housing for the elderly.

CPD also has a technical assistance contract with Maintenance Central for Seniors in Detroit, an organization which has done an outstanding job of offering home repair and rehabilitation services for the elderly, under foundation grants and CDBG funds.

Under the contract, Maintenance Central is sponsoring three conferences in Baltimore, Milwaukee, and Oakland to teach other cities and nonprofit organizations about the philosophy of repair rather than replacement and their management techniques which include doing the work directly for elderly homeowners rather than leaving it up to them to get their own contractors.

E. 701 Comprehensive Planning Assistance

Comprehensive planning assistance (701) is available to regional bodies and other units of government not receiving CDBG. Its purpose is to increase the capacity of local governments to carry out comprehensive planning. Grant recipients are required to undertake activities which achieve:

(1) Conservation and improvement of existing communities.

(2) Expansion of housing and employment opportunities and choices for low-income and minority households; and

(3) Promotion of orderly and efficient growth and development.

During 1980, the planning assistance (701) program legislation was revised and it now addresses housing needs of elderly and handicapped persons, among other groups. When this legislation is implemented all 701 recipients will be required to give consideration to the housing needs of the elderly and the handicapped.

VI. INTERAGENCY AGREEMENTS

A. Alcoholism—HUD/HHS

A HUD-HHS agreement was formulated and signed to organize and present a series of alcoholism outreach programs at selected PHA's across the country. The alcoholism programs were designed to deal with the problems of alcoholism as it affects family life, especially the lives of youth and the elderly. Attention was also given to the interaction of alcoholism and housing management.

B. Congregate Housing Services Work Group

Coordination with and involvement of other Federal agencies offering benefits to HUD's public housing for the elderly continued and expanded in fiscal year 1980. Programs of the Department of Health and Human Services (especially those under the Administration on Aging (AoA)) have been drawn upon to serve nutrition and other needs such as home-health care. With the implementation of the congregate housing services program, close collaboration between HUD and AoA became necessary. The CHSP has entered its second year of grants to eligible PHA's and section 202 sponsors, with the interagency CHSP work group playing a role in discussion and approval of HUD's selection criteria and program operations standards. The work group consists of representatives from HUD, Administration for Developmental Disabilities, Administration on Aging, and others, including Farmers Home Administration.

C. Congregate Housing Services Program Evaluation—HUD/HHS (AoA)

An agreement between HUD and AoA was formulated and signed. The agreement provides for the transfer of AoA funds to HUD to assist in the financing of the CHSP evaluation. The agreement also outlines the mutual responsibilities of HUD and AoA in administering the evaluation contract.

D. Public Housing Urban Initiatives/Social Service Agreement—HUD/HHS

The Administration for Public Services (APS) of the Department of Health and Human Services and the Offices of Public and Indian Housing and Neighborhoods, Voluntary Associations and Consumer Protection (NVACP) completed an agreement to cooperate in implementing the Public Housing Urban Initiatives/Social Service Agreement in support of the President's Urban Policy. The goal of the agreement was to insure the delivery of comprehensive human services to those in need of the services. It was specifically designed to improve service access to public housing residents in the 33 cities designated in the targeted rehabilitation component of the Public Housing Urban Initiatives/Social Service Agreement.

E. Anticrime Program—HUD/HHS/Justice/Labor

The anticrime program involves three Federal agencies with HUD as the administrative lead. It is a comprehensive attempt to reduce crime and the fear of crime in public housing developments and their neighborhoods. Thirty-nine localities across the country were funded for anticrime programs through interagency agreements with the Department of Labor, the Department of Justice, and the Department of Health and Human Services, along with the Department of Housing and Urban Development.

F. Interdepartmental Working Group on Development and Implementation of a Federal Manpower Policy for the Field of Aging

HUD is represented in the Interdepartmental Working Group on Development and Implementation of a Federal Manpower Policy for the Field of Aging. This work group is charged with the preparation of a biennial report to Congress on the status of personnel working in the field of aging.

G. White House Miniconference on Housing for the Elderly

HUD was active in the development of agenda for the White House Miniconference on Housing for the Elderly which took place in October 1980, in Washington, D.C. HUD staff served as facilitators and resource persons during the conference.

H. Title IIIc Nutrition Program—HUD/HHS (AoA)

Agreements in effect between HUD and the Administration on Aging on nutritional and social services for the elderly in HUD-assisted housing continue to produce programs and services. For example, as reported last year, over 1,500 local housing authorities and section 202 sponsors provide onsite facilities for the AoA title IIIc nutrition program under an agreement between HUD and AoA. We estimate these sites serve at least 25,000 elderly.

ATTACHMENT 1.—*Sample of fiscal year 1980 UDAG projects which directly benefit the elderly*

Mobile, Ala	Construct convalescent center with nursing home, medical clinic, and apothecary and elderly care facility.

Wilmington, Del	Nursing home site improvements, new construction and equipment purchase.
Pollock, La	Conduct nursing home, paved parking area, sewage facility and furnishing.
Denton, Md	Construct water improvements for nursing home.
Boston, Mass	Develop elderly health facility on urban renewal site.
Gowanda, N.Y	Construct nursing home, purchase capital equipment, construct offsite water and sewer facilities.
Jamestown, N.Y	Improve street and site, water, sewer, parking and construct intermediate care facility.
West View, Pa	Construct neighborhood commercial center, elderly high-rise, and townhouses.
Toledo, Ohio	Acquire land and construct nursing home, develop medical facility, expand training.
Salem, W. Va	Nursing home facility, public improvements, and energy efficient solar/gas heating system/installation.
Hillman, Mich	Construct nursing home and extend water/sewer facility and access road to site.
Princeton, W. Va	Construct sewer line to nursing home.

APPENDIX

A Summary of HUD Housing Units for the Elderly[4]

All figures represent number of projects/units currently insured by FHA unless otherwise noted.

Section Number	Program	Status	No. of Projects	No. of Units	Value	App. No. of Eld. Units	% of Eld. Units	Report Period
Construction Projects								
Title II	Low-income Public Hsng.	Active	10,750	1,200,000	Not Available	552,000[1]	46%	Cum.thru 9/30/79
202	Direct Loans for Hsng. for Elderly & Handica.	Inactive[2] Active[3]	330+ 1,211	45,275 91,716	574,980,000 3,329,074,000	45,275 87,522	100% 95%	Cum.thru 1972 5/31/80
231	Mortgage Insurance for Hsng. for Elderly	Active	477	84,116	1,082,966,264	84,116	100%	Cum.thru 12/79
221(d)3	Multifamily Rental Hsng. for Low & Moderate	Active	3,417	346,383	5,337,557,961	55,602	7%	Cum.thru 12/79
221(d)4	Income Families	Active	3,874	447,938	8,939,941,234			
235	Home Ownership Asst. for Low & Moderate Income families	Inactive[2] Active	472,059[7] 40,862	473,032 40,893	8,456,660,790 1,352,920,895	Figures not Currently Available		Cum.rev. Program thru 3/80
207	Multifamily Rental Hsng.	Active	2,639	285,108	3,937,745,205	3,421	1.2%	Cum.thru 12/79
236	Rental and Coop. Asst. for Low Income families	Inactive	4,052	454,645	7,479,970,182	53,799	12%	Cum.thru 12/78
202/236	202/236 Conversions	Inactive	182	28,306	482,032,750	28,306	100%	Cum.thru 12/78
232	Nursing Homes & Intermediate Care Facilities	Active	1,271	(beds) 145,262	1,581,565,981	145,262	100%	Cum.thru 12/79
Non-Construction Programs								
8	Low-Income Rental Asst. Existing[4]	Active	9,446	821,418	N/A	240,742	29%	Cum.thru 5/31/80
	New Const.[4,5]	Active	8,393	538,561	N/A	290,447	54%	5/31/80
	Substantial[4,5] Rehabilitation	Active	1,650	112,828	N/A	40,107	35%	5/31/80
312	Rehabilitation Loans	Active[6]	75,913	N/A	780,225,000	N/A	App.25% of Loans	Cum.thru 9/30/79
23	Low Rent Leased Hsng.	Inactive[2]	N/A	163,287	N/A	54,000+	35%	Cum.thru 12/75

1 Data does not indicate how many of these units are designed specifically for the elderly.
2 Figures for original program reported through program revision.
3 Figures for revised Section 202/8 represent cumulative project reservations as of 5/31/80.
4 Figures represent cumulative fund reservations through reporting date.
5 Figures do not include Section 8 commitments attached to Section 202/8 fund reservations.
6 Figures represent loan commitments only.
7 Figures represent number of mortgages.

This table was compiled by the Office of the Special Assistant for Elderly Housing and Special Programs, with the assistance of the Housing Budget Division, Management Information Systems Division, Multifamily and Single Family Insured Branches, and the Data Systems and Statistics Branch in the Office of Housing.

ITEM 8. DEPARTMENT OF THE INTERIOR

DECEMBER 18, 1980.

DEAR MR. CHAIRMAN: In response to your letter of October 30, 1980, we have summarized below the services provided to Indian elderly under the Bureau of Indian Affairs' Housing Improvement Program (HIP).

"The Bureau of Indian Affairs has a Housing Improvement Program (HIP) which is a repair and renovation program of existing housing on Indian reservations and in Indian communities. This program is aimed at improving the standards of housing for those people who are not qualified to receive this assistance from any other source. Although eligibility to participate in HIP is not based upon the age of the applicant but rather upon need for decent housing, a good many recipients of HIP involve elderly since their qualifications and participation in other federally assisted housing programs are more unlikely."

We hope that the above information will be of use to you in the preparation of your annual report, "Developments in Aging."

Concerning other programs and activities of the Department of the Interior that may have an impact on the elderly, please note that a separate direct response will be sent to you by the Heritage Conservation and Recreation Service.

Sincerely,

THOMAS W. FREDERICKS,
Deputy Assistant Secretary—Indian Affairs.

ITEM 9. DEPARTMENT OF JUSTICE (LAW ENFORCEMENT ASSISTANCE ADMINISTRATION)

DECEMBER 4, 1980.

DEAR MR. CHAIRMAN: This is in response to your letter requesting information from the Law Enforcement Assistance Administration for use in the Special Committee on Aging's annual report, "Developments in Aging."

In March of this year, the President recommended elimination of the financial assistance programs authorized by the Justice System Improvement Act of 1979 and administered by LEAA. The fiscal year 1981 Department of Justice appropriations bill approved by Congress includes no funds for LEAA grants. While the Agency has been active in the past in supporting various types of programs to assist the elderly, I regret that it appears that we will not be in a position to fund any new projects. Action has been taken to prepare for an orderly phaseout of LEAA activities.

The Special Committee on Aging's past interest in and support for the programs of the Law Enforcement Assistance Administration is appreciated.

Sincerely,

HOMER F. BROOME, Jr., *Administrator.*

ITEM 10. DEPARTMENT OF LABOR

JANUARY 12, 1981.

DEAR MR. CHAIRMAN: Enclosed, in accordance with the recent request of the committee, is a summary of the programs and activities of the Department of Labor for 1980 related to aging. This summary describes the services provided under programs administered by our Employment and Training Administration and Pension and Welfare Benefits Program. I hope this will be of assistance to you in preparing your report, "Developments in Aging."

Sincerely,

RAY MARSHALL, *Secretary.*

Enclosure.

EMPLOYMENT AND TRAINING ADMINISTRATION PROGRAMS

The Employment and Training Administration has responsibility for providing or administering employment, training, and related services for the Nation's older citizens through a part-time community service employment program, comprehensive employment and training, and public service employment programs, and the employment service system.

The extent of the increasing need to assist older workers to obtain jobs is related to a number of trends in our society:

- The difficulty older workers experience in obtaining jobs because of such factors as discriminating personnel policies, obsolete skills, limited training opportunities, and lack of confidence.
- The disproportionate impact of inflation on older workers because of increasing prices, fixed annuity incomes, and inadequate retirement income.
- The real and anticipated impact of funding problems of retirement income systems, including the social security system.
- The increasing number and proportion of older people, resulting from declining birth and death rates (those persons over 55 years of age will increase from 46 million in 1980 to 54 million in 2000, whereas the 18–24 age group will decrease from 29 million in 1980 to 24.7 million during this same period); and
- The high incidence of poverty among older people (The Census Bureau reports over 8 million people 55 and over are classified as poor or near poor).

In order to respond to these trends, the Department of Labor provides support for the activities which are discussed in this report.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

The U.S. Department of Labor administers the senior community service employment program (SCSEP). This program, authorized by title V of the Older Americans Act, offers subsidized part-time employment to low-income persons age 55 and above. Although theoretically almost 8 million older workers are eligibile for this program, the number is much smaller due to health and other reasons. Nevertheless, it is safe to say SCSEP serves less than 1 percent of those eligible. Program participants work an average of 20–25 hours a week in a wide variety of community service activities and facilities including day care centers, schools, hospitals, senior centers, and beautification, conservation, and restoration projects. In addition to subsidized community service jobs, SCSEP participants receive yearly physical examinations, personal and employment-related counseling, job training and, in some cases, referral to unsubsidized jobs. Because of its exclusive focus on economically disadvantaged older people, its economic and socio-psychological benefits to participants, and its contribution to community services, many consider SCSEP one of the best Federal programs for the elderly.

Activity under this program was, in earlier years, sponsored by a group of four national organizations (Green Thumb, Inc., the National Council of Senior Citizens, the National Council on the Aging, and the National Retired Teachers Association/American Association of Retired Persons) and the U.S. Forest Service. Until July 1, 1977, they sponsored all local projects being conducted in 47 States, the District of Columbia and Puerto Rico. During the July 1976 through June 1977 program year, the Department also awarded SCSEP grants directly to three State governments and four territories not covered by the national organizations (Alaska, Delaware, Hawaii, American Samoa, Guam, The Trust Territories of the Pacific Islands, and the Virgin Islands).

During the program year, from July 1976 through June 1977, the SCSEP subsidized about 15,000 jobs. Financial support for that period was provided by a $55.9 million supplemental appropriation during the last quarter of fiscal year 1976.

For the program year of July 1977 through June 1978, SCSEP was expanded to provide a new total of 37,400 jobs. Financial support for this period totaled $90.6 million and was provided from the Economic Stimulus Appropriations Act.

Funding for the 1978–79 program year totaled $200.9 million. This supported 10,100 new community service jobs, increasing the total to 47,500.

Beginning with the 1977–78 program year, SCSEP funds were divided with 80 percent going to national sponsors and 20 percent going to State governments.

In addition to the national organizations that have historically operated SCSEP projects, the Department added three new national sponsors in July 1978. Selected through a competitive process were the National Urban League, the Association Nacional Pro Personas Mayores, and the National Center on Black Aged.

The fiscal 1979 appropriation for SCSEP was $211.7 million. This amount was sufficient to sustain the 47,500 jobs, and an additional $8.9 million in funding was needed to support continuation of the 47,500 jobs during the 1979–80 program year.

The fiscal 1980 appropriation for SCSEP was $266.9 million. This included 4,750 new jobs, a 10 percent increase, bringing the total SCSEP jobs to 52,250. A portion of the appropriation was released early in 1980, in order that the 4,750 new jobs could be filled before July 1, 1980, the start of the 1980–81 program year. The 4,759 jobs were divided so that 55 percent (2,612 jobs) were administered by State sponsors and 45 percent (2,138 jobs) were administered by national sponsors. The other 47,500 jobs were allocated in the same manner in the past. A report covering SCSEP activities for the program year ending June 30, 1980 follows.

SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM

Performance report for the 1979–1980 program year
(July 1, 1979–June 30, 1980)

I. Funding (in millions)	$229.1
II. Enrollment levels:	
Authorized positions established	52,250
Unsubsidized placements	6,251
III. Summary of characteristics—persons actually enrolled:	
Sex:	*Percent*
Male	34
Female	66
Education:	
8th grade and under	38
9–11	22
High school grad or equivalent	27
1–3 years college	9
4 years college and above	4
Veteran	9
Racial/ethnic groups:	
White	69
Black	21
Hispanic	6
American Indian/Alaskan	2
Asian/Pacific Islands	2
Economically disadvantaged (100 percent of poverty level)	87
Age:	
55–59	21
60–64	28
65–69	28
70–74	15
75 and over	8
IV. Areas of community service in which participants were employed:	
Service to the general community	51
Education	11
Health/hospitals	4
Housing/home rehabilitation	2
Employment assistance	1
Recreation, parks, and forest	9
Environmental quality	2
Public works and transportation	5
Social services	11
Other	6
Services to the elderly	49
Project administration	3
Health and home care	5
Housing/home rehabilitation	4
Employment assistance	1
Recreation/senior citizens	8
Nutrition programs	13
Transportation	3
Outreach/referral	9
Other	3

V. Average hourly wage: $3.21.

The 1981 fiscal year has retained the same number of job slots, 52,250. The budget, however, increases slightly to $267.1 million in order to sustain the current level of activity.

COMPREHENSIVE EMPLOYMENT AND TRAINING PROGRAMS AND PUBLIC SERVICE EMPLOYMENT PROGRAMS

Persons in all working age groups participate in activities under the Comprehensive Employment and Training Act (CETA), which provides for comprehensive employment and training programs and public service employment. One of the changes in the statute was a major reordering of programs under different titles. The following table indicates the numbers of persons in the upper age groups who participated in comprehensive employment and training programs (new title II–A, –B, –C) and public service employment (new title II–D and VI) during fiscal 1980.

ENROLLMENT TABLE, CETA, FISCAL YEAR 1980

[Preliminary estimates]

	Total	Percent	Title II A, B, C	Percent	Title II-D	Percent	Title VI	Percent
Total participants	2,075,430		1,190,722		482,952		401,756	
45 to 54	120,384	5.8	50,010	4.2	38,636	8.0	31,738	7.9
55 and over	80,340	3.8	30,959	2.6	26,079	5.4	23,302	5.8
Total over 45	200,724	9.7	80,969	6.8	64,715	13.4	55,040	13.7

CETA, as reauthorized in 1978, and implementing regulations, provide a strengthened focus on the employment problems of older workers. Title III specifically provides that the Secretary of Labor shall insure that prime sponsors' plans provide the details of the specific services to be provided to individuals who are experiencing severe handicaps in obtaining employment, including those who are 55 years of age and older. Title III provides broad authority for research and training policies and programs to focus on providing older workers a more equitable share of employment and training resources to reflect their importance in the labor force.

The current CETA regulations are designed to enhance the effectiveness of CETA programs. Major emphases include targeting services to persons most in need and providing equitable services to significant segments of the eligible population (age, race, sex and national origin groups); ensuring comprehensive planning and delivery through coordination of the various employment and training activities; focusing on the transition of participants into unsubsidized employment; and providing for improved management control to ensure the integrity and efficiency of the program and to prevent program fraud and abuse.

CETA—NATIONAL PROGRAMS

On April 1, 1977, the Department of Labor provided the Administration on Aging with CETA discretionary funds to continue 15 grants for older worker employment projects which were originally authorized under title X of the Public Works and Economic Development Act. These projects were later administered and funded by the Employment and Training Administration through direct grants.

During 1978, as many as 5,300 persons were employed in the program. However, the Department has encouraged a gradual reduction in the number of enrollees through a transfer of enrollees into title V of the Older Americans Act or into unsubsidized jobs. Currently, about 1,700 persons are working in the program. The remaining participants who do not transfer into other jobs or programs will be supported until September 30, 1981, after which time the availability of funding is uncertain. The Employment and Training Administration has budgeted $5.7 million for this purpose.

EMPLOYMENT SERVICES TO OLDER WORKERS

BACKGROUND

Within the broad framework of the Wagner-Peyser Act of 1933, as amended, which established the Federal-State employment service system, the State employment service agencies provide intensive counseling, assessment, job development, placement and referral to training and social services to meet the employment-related needs of middle-aged and older jobseekers.

The ultimate objective of these services is to minimize the duration of unemployment experienced by men and women who lose their jobs when in their mid-forties or later years, and to assist all middle-aged and older workers in obtaining and remaining in employment which utilizes their highest skills.

Although the unemployment rate for middle-aged and older workers is lower than for the younger age groups, the duration of unemployment experienced by men and women who lose their jobs when in their mid-forties or later tends to increase. The Age Discrimination in Employment Act of 1967, as amended, recognizes this trend in its coverage of most workers who are at least 40 years of age but less than 70. For purposes of recordkeeping and statistical reporting, the employment service uses age 45 as a reference point for the term "older workers."

FISCAL YEAR 1980 ACCOMPLISHMENTS

In fiscal 1980, the State employment services placed 355,171 individuals age 45 and over in jobs. This reflects the placement of more than half of the older workers referred by State employment service offices to job openings as well as the placement of nearly 18 percent of all new and renewal applicants age 45 and over. This placement figure also represents an increase in fiscal 1980 in the number of older workers for whom job development contacts were made. Over 14 percent of the older workers were placed as a result of job development contacts.

The following table, "Employment Services for Older Workers," provides comparative data on public employment services to jobseekers age 45 and over, 55 and over, and to all applicants regardless of age.

A total of 103,862 veterans age 45 and over were placed in jobs by the State employment services in fiscal 1980.

The employment services in Arkansas, Illinois, Massachusetts, and Virginia augmented their staff with specially trained low-income retired men and women who work on a half-time basis providing intensive job development and community outreach services for applicants age 55 and over. Similar services are also provided by the Missouri, Ohio, and New Jersey State employment services.

EMPLOYMENT SERVICES FOR OLDER WORKERS, FISCAL YEAR 1980

[Numbers in thousands, except percents]

55 employment services for older workers	Fiscal year 1980 (all fund sources)			Change from 1 yr ago[1] (percent)		
	Total	Age 45 and over	Age 55 and over	Total	Age 45 and over	Age 55 and over
New applicants and renewals	17,882.1	2,255.6	867.5	16.7	15.8	6.5
Individuals referred to job openings	7,719.7	755.8	291.5	−4.2	−1.6	.63
As percent of new applicants and renewals	43.2	33.5	33.6	(52.5)	(39.4)	(35.6)
Individuals placed in jobs	4,014.6	355.2	139.3	−10.1	−7.4	−3.8
As percent of individuals referred to job openings	52.0	46.9	47.8	(55.6)	(50.1)	(51.0)
As percent of new applicants and renewals	22.5	15.7	16.1	(29.2)	(19.7)	(18.1)
Individuals counseled	1,106.3	127.7	45.4	4.3	.71	−.9
As percent of new applicants and renewals	6.2	5.7	5.2	(6.9)	(6.5)	(5.6)
Individuals placed after counseled	273.4	24.3	8.5	−8.7	−9.8	−2.0
As percent of individuals counseled	24.7	19.0	18.7	(28.2)	(21.2)	(20.0)
As percent of new applicants renewals	1.5	1.1	1.0	(1.9)	(1.4)	(1.1)
Individuals placed as a result of job development	520.7	51.4	19.7	−11.6	−9.5	−7.2
As percent of new applicants and renewals	2.9	2.8	2.3	(3.8)	(2.9)	(2.6)
Individuals for whom job development contact made	1,858.0	264.9	103.9	7.0	8.9	9.9
As percent of new applicants and renewals	10.4	11.7	12.0	(11.2)	(12.4)	(11.5)
Individuals tested	826.7	60.5	16.7	.74	7.2	17.7
As percent of new applicants and renewals	4.6	2.7	1.9	(5.3)	(7.9)	(1.9)
Individuals referred to training	331.7	20.7	6.5	13.5	−.42	−3.5
As percent of new applicants	1.9	.9	.7	(1.9)	(1.1)	(.9)
Individuals referred to supportive services	1,413.0	203.8	81.5	26.5	30.5	34.1
As percent of new applicants and renewals	7.9	9.0	9.4	(7.3)	(8.0)	(7.5)

[1] Fiscal year 1979 percentages shown in parentheses for comparison.

Source: Office of Program Review, U.S. Employment Service.

State employment services participated in the annual observance of National Employ the Older Worker Week to foster public awareness of the benefits of hiring older workers and to emphasize year-round public employment services to older jobseekers.

A staff member of the U.S. Employment Service served on the Interdepartmental Task Force on Information and Referral created by the Cabinet-level Committee on Aging established under the Older Americans Comprehensive Service Amendments of 1973 (Public Law 93-29). The task force is concerned with implementation of the interdepartmental agreement on information and referral for older people signed by the Employment and Training Administration and 13 other Federal departments and agencies on December 21, 1974.

FISCAL YEAR 1981 INITIATIVES

(A) Provision of promotional and technical support for State employment service participation in the 1981 observance of National Employ the Older Worker Week.

(B) Continued involvement in the Interdepartmental Task Force on Information and Referral through increased emphasis on information and referral services in programs funded under the Comprehensive Employment and Training Act and title V (senior community service employment program) of the Older Americans Act, as amended.

(C) Initial and refresher training of new and onboard local office staff by all State employment services as needed in techniques of counseling, placing, and providing other basic and support services for older jobseekers.

(D) Continued promotion of public service employment cooperation with State and area agencies on aging and other organizations concerned with employment of older people.

RESEARCH AND DEVELOPMENT

The Employment and Training Administration's Office of Research and Development conducts a program of research, experimental and demonstration projects to improve and/or develop new employment, training and income maintenance programs, policies and initiatives. The program includes institutional grants to enable universities to strengthen their capability to conduct research and to train specialists in the employment and training field, as well as grants to support doctoral dissertation research and post-doctoral studies to develop new approaches to solve employment and training problems or to contribute to policy formulation. Many projects focus on the needs of specific target groups such as older workers, minority group members, offenders, veterans, women and youth. Some projects concerned with the employment-related problems of older workers are cited below.

A. Recently Completed Projects

1. Social Security and the Labor Supply of Older Men

The major objective of this study was to estimate the effects of social security and the associated earnings test on the retirement rates of men over 62. An analysis of National Longitudinal Survey's data (described below, under ongoing projects) indicated that changes in the earnings test between 1970 and 1974 had no measurable effect on retirement behavior. The study results also suggest that eliminating the earnings test will not increase labor supply but will increase the cost to the government of Social Security pensions.

2. Research and Development Strategy on the Employment-Related Problems of Older Workers

This study, completed in 1978, includes a systematic examination of all relevant older worker data, a review and evaluation of ongoing older worker programs, and an analysis of older worker policy issues and priorities. A major objective was to identify knowledge gaps and innovative programmatic approaches which might be addressed in research and development projects as a basis for improving programs and policies directed towards the employment-related problems of older persons. The study is expected to provide guidance for older worker research and development projects over the next several years.

3. The Preretirement Years: A Longitudinal Study of the Labor Market Experience of Men

This study probes the relationship of factors influencing the work behavior and experience of men aged 45 to 59 in 1966. The data were provided by the National Longitudinal Surveys (described below, under ongoing projects). The chief finding of this study was that pension coverage and tenure inhibited job changes by older workers. This study also found that health limitations caused lower earnings and labor force participation rates.

4. Program Participation of Elderly Hispanic Americans

A survey was conducted of 600 elderly Hispanic Americans in Riverside County, Calif., to study their participation in employment and training programs under the Comprehensive Employment and Training Act and the Older Americans Act. The major findings of the survey are that elderly Hispanic Americans have a low participation rate in these programs and that their knowledge or awareness of the programs is minimal. It has been recommended that programs should be developed which are aimed specifically at the Hispanic elderly and are staffed with bilingual-bicultural personnel.

5. National Program for Selected Population Segments (NPSPS)

One of the target groups of this project was older workers. In two areas this project trained older persons as homemaker or health aides to assist other elderly persons confined to their homes. Unexpectedly, many trainees qualified for nurse's aide or orderly certificates as a result of their training. Many took full-time jobs in hospitals and nursing homes in addition to working in private homes. In two other areas, the project offered more general counseling and placement assistance for elderly persons who may have been forced into early retirement. In another area, the NPSPS project for older workers coordinated existing services for the elderly and provided them with information concerning these services. The project paid the wages of 21 older worker coordinators who provided information and referral services for other elderly persons in the community.

6. Demonstration of Development and Testing of Job Sharing (Project JOIN)

A project to develop and test job sharing in the Wisconsin civil service system for persons wanting to return to work part time, for persons planning to retire, and for full-time employed persons who prefer to work part time. The study was designed to measure the productivity of those in conventional work situations and to measure the impact of creating less than full-time jobs on the balance of the work unit in which persons sharing jobs are located. The study findings indicate that job sharing can be implemented successfully, and can result in benefits to the employing organization as well as to the workers.

7. Paper on Socioeconomic Policies and Programs for the Elderly

In response to a request from the Organization for Economic Cooperation and Development a paper was prepared on socioeconomic policies and programs for the elderly. The paper describes and analyzes policy options and related programs, with emphasis placed on employment and related social programs and policies conducive to the labor market participation and social and community involvement of the elderly.

8. Utilization of Retired Teachers as a Supplemental Educational Resource

A study was undertaken to determine the feasibility of using retired teachers to make a significant impact on the solution of educational problems in the District of Columbia through the exercise of their lifetime skills, without undercutting the incomes or ambitions of younger teachers. The results indicate that a demonstration "emeritus teachers" project can be undertaken in the District of Columbia with a good chance of success. Such a demonstration project is underway.

9. Labor Supply Function for Older Males (Doctoral Dissertation Grant, Cornell University)

This study investigated the determinants of pension supply by firms and pension demands by workers. The dissertation offers some support for the contention that "quality regulation" of pension plans may result in the dissolution of some existing plans and hinder the establishment of new plans. It argues that, for a variety of reasons, the Employee Retirement Income Security Act may lead to a reduction in the pension coverage of American workers.

10. Determinants of Age of Retirement and Patterns of Labor Supply (Doctoral Dissertation Grant, University of Wisconsin)

This study provides added information on the factors influencing the retirement decisions of older workers, with the analysis focused on patterns of labor supply before and after retirement and on age at retirement.

B. Ongoing Projects

1. National Longitudinal Surveys (NLS) of Labor Force Behavior

A study of the relationships of factors influencing the labor force behavior and work experience of four groups: men aged 45–59 in 1966; women 30–44 in 1967; and men (1966) and women (1968), 14–24. The study focuses on the interaction among economic, sociological and psychological variables that permit some members of a given age-education-occupation group to have satisfactory work experiences while others do not, and entails several consecutive surveys of each group. Interviews were initiated in the years cited above and repeated at various time intervals through 1980. In 1979, a new youth cohort of 13,000 men and women aged 14–21, with over-representation of blacks, Hispanics, and poor whites, was added to the NLS. Current plans are to collect additional data on the initial four groups through 1983 and on the new youth cohort through 1984.

2. Demonstration of Development and Testing of Alternative Employment Patterns for Older Workers

A project to develop and test a variety of employment options in the Wisconsin State civil service for persons approaching retirement age (55) and for those who have already retired but would like to reenter the work force in an option other than the traditional 5-day, 40-hour work week. Options include various part-time and full-time work schedules. Analyses will be conducted with respect to factors such as the effects on income, job satisfaction, morale, health and productivity; and comparisons of job option participants and a matched standard work-week group. A major objective is to develop a prototype preretirement employment policy for the State of Wisconsin with the model structured so that its components could be used by other State and local governments.

3. Postretirement Work Experience of Nonsupervisory Personnel

A study to determine to what extent and under what conditions persons receiving private pension benefits continue to engage in paid employment. The study focuses on nonsupervisory personnel from three large companies, which provides a data base suitable for comparison with an earlier study of professional and managerial personnel from the same firms.

4. Retired Teachers as Tutors

A project to demonstrate and assess the effectiveness of utilizing the services of retired teachers as volunteers in a program to improve the reading and math skills of elementary school pupils in the District of Columbia. The project is designed to determine the degree to which retired teachers gain satisfaction and a sense of accomplishment by utilizing their lifetime skills, as well as to measure the effectiveness of tutoring in improving the performance of students who need remedial assistance.

5. Early Retirement and the Labor Market Dynamics of Older Workers (Doctoral Dissertation Grant, Yale University

A study of early retirement and its effects, with the objective of developing information on unemployment compensation, social security, and other retirement areas.

C. Contemplated Projects

Consideration is being given to projects concerned with tapered or phased retirement, employment-related problems of minority older workers, factors associated with continued employment versus withdrawal from the labor force, employment needs of retired workers, relationships between age and employment, ways to increase the labor force participation of "discouraged" older workers out of work, and the occupational capabilities of middle-aged and older workers.

OTHER PROGRAMS FOR OLDER WORKERS

RURAL TRANSPORTATION INITIATIVE

This interagency program is intended to enhance the access of people in nonurbanized areas to health care and social services, as well as to shopping, education, recreation, other public services and employment, by encouraging the maintenance, development, and use of encouraging the maintenance, development, and use of coordinated transporation services. The program specifically focuses on assuring that necessary transportation resources are available in the context of ongoing programs, removing administrative barriers to coordination of services as fully and expeditiously as possible, and providing technical assistance and support to State and local officials in the development and evaluation of such services. Participants in the implementing interagency agreement include the Departments of Labor; Transportation; Health, Education, and Welfare (now HHS); and Agriculture; and the Community Services Administration.

The Department of Labor is providing funding to train and employ workers such as drivers, dispatchers, and mechanics for jobs in public transportation systems in the 14 demonstration States. Grants totaling approximately $4.7 million in CETA title III discretionary funds were awarded to five of the national nonprofit organizations that sponsor title V senior community service employment programs under the Older Americans Act. The programs are being run in accordance with SCSEP regulations and persons hired must meet the SCSEP eligibility criteria.

SUBSCRIPTIONS

For over 10 years the Employment and Training Administration has been purchasing a bulk 12-month subscription to "Aging and Work," a quarterly journal published by the National Council on Aging. Through this subscription the Employment and Training Administration provides copies of the journal to CETA prime sponsors, the local offices of State employment security agencies, and State and area agencies on aging.

PROJECTS FOR OLDER WORKERS

CETA section 308 authorizes programs to facilitate increased labor force participation of low-income persons age 55 and over.

Pursuant to the mandate of section 308 of CETA, the Department of Labor awarded a total of $2 million to four national nonprofit organizations to develop and administer innovative and replicable job training programs for low-income persons 55 years of age or older. The program's intent is to provide low-income, unemployed or underemployed older workers with skills needed to obtain permanent unsubsidized employment or training to improve skill levels and career opportunities, as well as address specific needs of individuals who have not been in the labor force for a number of years.

WEATHERIZATION

The Department of Labor's major involvement in weatherization dates back to an interagency agreement signed in 1977 between Labor, the Federal Energy Administration (now the Department of Energy), and the Community Services Administration (CSA). The weatherization programs assist low-income families and individuals, particularly the elderly and the handicapped. The Department, through CETA prime sponsors, provides CETA workers to install insulation and related materials.

In fiscal 1979, funds for weatherization program materials and administration were consolidated in one appropriation for the Department of Energy (DOE). DOE was to make grants to State energy offices or State economic opportunity offices. These State agencies were, in turn, to subgrant funds to local community action agencies (CAA's) to operate weatherization programs. CAA's were to use DOE funds for materials and project supervision and to negotiate agreements with CETA prime sponsors for installation laborers. Further, the 1978 CETA amendments included several new provisions to enhance CETA participation in weatherization projects and activities.

In addition to the major emphasis placed on weatherization under CETA public service employment programs, other CETA programs have also carried out weatherization and related energy conservation activities. Under the older worker program, a number of projects have been launched which provide weatherization services in cooperation with various other agencies including the Department of Housing and Urban Development, CSA and the Administration on Aging. Because workers shift among activities in older worker projects, a precise count of the numbers of workers involved in weatherization activities is not available. However, it is estimated that between 1,500 and 2,000 older workers are engaged in housing rehabilitation and weatherization activities on homes of older persons. A substantial number of title V workers (approximately 3,000) are also engaged in weatherization and home rehabilitation projects.

SUMMARY OF ACTIVITY OF PENSION AND WELFARE BENEFIT PROGRAMS AFFECTING AGING

The Office of Pension and Welfare Benefit Programs (PWBP), an organization within the Department of Labor (DOL), administers title I of the Employee Retirement Income Security Act of 1974 (ERISA). The purpose of ERISA is to protect retirees who are receiving benefits from private sector pension plans and welfare plans, workers who participate in private pension and welfare plans and the beneficiaries of both retirees and active participants—to see that workers are not required to satisfy unreasonable age and service requirements before becoming eligible for pension plan participation and vesting benefits; to see that the money will be there to pay pension benefits when they are due; to see that plans and plan funds are managed prudently; to see that retirees and workers are supplied with the information needed by them regarding their plans; to see that spouses of retirees are given protection; and to see that the benefits of retirees and workers are protected if the plan should terminate.

SUMMARY OF PWBP ACTIVITY

DOL is given the following responsibilities under **ERISA**:

A. Enforcement

PWBP is responsible for enforcing provisions of ERISA, with the greatest emphasis being placed on obtaining compliance with the fiduciary provisions. These provisions require, among other things, that plan trustees and administrators shall perform their plan duties solely in the interest of participants and beneficiaries. Investigations are conducted and where violations are found, the Secretary of Labor may file a civil action to recover plan assets or remove those persons from their position of trust, among other remedies. The Secretary also may intervene on behalf of any retirees, active plan participants or their beneficiaries who allege that a violation of fiduciary responsibilities has occurred in the management of a plan's financial affairs. Where violations are discovered, PWBP's general priorities are the following: Move quickly to prevent any future loss of assets; recover assets that were lost; and, where appropriate, remove the trustees responsible for the loss.

Strengthening the compliance program was the major priority for PWBP in 1980. As part of this effort, a number of program improvements were implemented in 1980, which included efforts to continue improving targeting methods, closely monitoring and directing field activities, and providing additional specific guidelines to the field regarding our compliance strategy.

The program improvements implemented during 1980 were part of PWBP's effort to shift to an almost total emphasis on conducting fiduciary investigations, which protect and recover plan assets in the event of misuse. This is critical to insuring that funds are available to pay promised benefits from pension and welfare plans. As a result, 1,455 fiduciary cases were closed during this fiscal year.

B. Reporting and Disclosure

ERISA obligates plan administrators to furnish to participants and beneficiaries certain information about plan operations and finances. Such information shall include a copy of the summary plan description, summary annual report and individual benefit statements. Plans must also make available to them on request certain other plan documents, including the latest annual report, bargaining agreement and trust agreement.

In addition, ERISA requires plan administrators to file certain reports with the Department of Labor Internal Revenue Service (IRS) and Pension Benefit Guaranty Corporation (PBGC). Reports which must be filed with DOL include: the annual report (the Form 5500 series), and the summary plan description, a booklet which plans provide to participants and beneficiaries explaining plan benefits. These reports and other documents are maintained in a disclosure room for public examination. Copies of the reports are available for a small fee. The Department also accepts telephone and mail requests for copies of the reports. Requests should be directed to: Department of Labor, PWBP Public Disclosure, Room N-4677, 200 Constitution Avenue N.W., Washington, D.C. 20216. The telephone number is (202) 523-8773.

C. Public Education and Information

The Office of Communications and Public Services (OCPS) has primary responsibility for implementing PWBP's public information program. It serves as a liaison with the public on ERISA-related issues and responds to their requests for information about the pension and welfare field. OCPS publishes literature and audio visual materials which explain in some depth provisions of ERISA, procedures for plans to effect compliance with the act, and the rights and protections afforded participants and beneficiaries under the law. In addition, it provides speakers on various topics affecting the pension and welfare field, and serves as a contact point for the media on all questions pertaining to ERISA.

During 1980, the National and field office staff of PWBP responded to 134,000 inquiries from plan participants, beneficiaries and other persons interested in the administration of plans. In fiscal year 1980, OCPS also distributed 660,000 copies of its publications explaining provisions of ERISA. Among the publications disseminated, the following are designed exclusively to assist the public in understanding the law and how their pension plans operate:

—What You Should Know About the Pension and Welfare Law (English and Spanish versions).
—Know Your Pension Plan.
—How to File a Claim for Benefits.
—Often Asked Questions About ERISA.

Further information about any of these services may be obtained by contacting the: Department of Labor, PWBP, OCPS, Room N-4659, 200 Constitution Avenue NW., Washington, D.C. 20216. The telephone number is (202) 523-8921.

D. Research and Development

PWBP conducts a coordinated program of research through contracts and in-house studies. The research program develops data on employee benefit plans which can be used as the basis for program modifications or policy decisions. It also analyzes economic issues related to retirement decisions and income.

During 1980, the following studies relating to pension plans and retirement were initiated:

(1) A study to analyze and test a comprehensive theory of why business firms offer pensions.

(2) A study of the relationship between expected and actual labor supply resources of older workers.

(3) A study to design and estimate a model of a worker's retirement decision.

(4) A study to analyze the effects of pensions on wage levels, and saving and retirement decisions.

(5) A study to determine the implications of ERISA funding requirements on firm behavior, workers and the stock market.

(6) A study of the financial incentives for early and disability retirement.

(7) A study to determine the effects of pensions and social security on the age of retirement.

EMPLOYMENT STANDARDS ADMINISTRATION PROGRAMS

On July 1, 1979, the Equal Employment Opportunity Commission (EEOC) assumed enforcement responsibilities previously carried out by the Department of Labor under the Age Discrimination in Employment Act of 1967 (ADEA), as amended, with respect to protection against age discrimination in private sector and State and local government employment. (The EEOC had already assumed responsibility on January 1, 1979, for ADEA enforcement in the Federal sector, for which the Civil Service Commission previously had jurisdiction.) Under Reorganization Plan No. 1 of 1978, which affected these transfers, the Department of Labor continues to be responsible for research (including studying the effects of the 1978 ADEA amendments) and for educational and informational activities under the ADEA relating to the expansion of employment opportunities for older persons.

In 1979, the Department awarded research contracts to enable the Secretary to fully implement the congressional directive in section 5 of the ADEA that calls for an appropriate study of institutional and other arrangements giving rise to involuntary retirement. The 1978 amendments to the act stipulated that the section 5 study include: (1) an examination of the effect on private sector and non-Federal public employment of raising the upper age limit from age 65 to 70, (2) determination of the feasibility of raising or eliminating the current (age 70) upper age limit, and (3) examination of the effects of the exemptions allowing mandatory retirement at ages 65 through 69 to tenured teaching personnel in institutions of higher education and of certain executive employees.

The research contracts awarded to assist the Department in meeting the section 5 study requirements will provide information on these and other issues related to involuntary retirement and the effect of raising the age at which mandatory retirement is allowed. Data on employment and retirement behavior of older persons are being analyzed to assess the impact of mandatory retirement on older workers and others in the labor force, including younger workers and minorities. A survey is being conducted to examine institutional settings and factors leading to mandatory retirement, the reasons for the establishment of mandatory retirement age standards and attitudes and perceptions regarding mandatory retirement. Responses of firms and employees to the change in the legally permissible mandatory retirement age under the ADEA have been investigated, including information concerning employer retirement, pension and personnel policies, and union retirement policies. Also, the effects of the executive employee exemption are being studied, and work under the contract focuses exclusively on investigating the effects of the temporary exemption for tenured teaching personnel in institutions of higher education. Smaller studies are also being conducted on the bona fide occupational qualification exemption, characteristics of older workers, and developments in employment opportunities for older workers. The results of the research are being utilized by the Department of Labor in developing its report on involuntary retirement for submission to Congress and the President.

ITEM 11. DEPARTMENT OF STATE

DECEMBER 19, 1980.

DEAR MR. CHAIRMAN: In response to the letter of October 30 from you and Senator Domenici to Secretary Muskie, we are pleased to supply the following information concerning activity related to the elderly.

In our letter of October 29, 1979, we mentioned the Supreme Court decision which upheld the constitutionality of age 60 as the mandatory retirement age for members of the Foreign Service. Since that time, the Congress, in passing the Foreign Service Act of 1980 (Public Law 96-465), raised the mandatory retirement age to 65 for members of the Foreign Service.

Other involvement in matters pertaining to the elderly during fiscal year 1980 except for the ongoing activities described in our letter of October 29, 1979, were limited to those United Nations initiatives with which the United States was closely identified. Most significant were the following:

—In December 1979, the United Nations General Assembly adopted resolution 34/153, a follow-on to resolution A/33/382 on which we commented in our report for fiscal year 1979. Most notably, resolution 34/153 urged full participation by all governments in the World Assembly on the Elderly, and requested the concerned specialized agencies of the United Nations system to give attention to the major issues concerning the aging.

—In May 1980, the Economic and Social Council in an effort to strengthen the United Nations planning mechanism for the Assembly, recommended to the General Assembly that there be a full-time Secretary General for the

World Assembly on the Elderly; that an Advisory Committee for the World Assembly composed of 23-member states be created and meet in early 1981; and that the World Assembly take place in Vienna, Austria, the last 2 weeks of August 1982. (The United States was appointed as 1 of the 23-member states on the Advisory Committee.)

—The first meeting of the 23-nation Advisory Committee will be expected to actually draft the conference agenda for approval by the General Assembly in the fall of 1981.

—On November 5, 1980, the United States presented a check for $250,000 to the Secretary General as a contribution to the World Assembly. The United States was the first Nation to contribute money to that voluntary fund, thereby highlighting U.S. interest in the Assembly.

—A United Nations World Conference on the United Nations Decade for Women dealing with equality, development, and peace, was held in Copenhagen, Denmark, in August 1980. The U.S. delegation to that meeting was strongly supportive of a draft resolution entitled "Elderly Women and Economic Security." This resolution was finally adopted by consensus by the conference. The resolution requested member states: (1) To insure that women are included in the planning process for and are appointed as members of their delegations to the World Assembly on the Elderly; (2) to give special attention to the problems that elderly women face in their societies; and (3) to collect data on elderly women for use by the World Assembly on the Aging.

—In June 1980, the International Labor Organization held its 66th Session in Geneva, Switzerland. One of the subjects on the agenda was a proposed recommendation which would insure that older workers would not be discriminated against. The U.S. delegation was fully supportive of this recommendation which was adopted by the conference.

Thank you for the opportunity to contribute to this year's committee report on the aging.

Sincerely,

J. BRIAN ATWOOD,
Assistant Secretary for
Congressional Relations.

ITEM 12. DEPARTMENT OF TRANSPORTATION

JANUARY 26, 1981.

DEAR MR. CHAIRMAN: I am pleased to forward to you the enclosed report which summarizes significant actions taken by this Department during the past year to improve transportation facilities and services for older Americans. Additional information will be submitted subsequently regarding the Urban Mass Transportation Administration's actions. This report is being forwarded to you in response to your letters of October 30 and November 26, 1980, to former Secretary of Transportation, Neil Goldschmidt, requesting information for part 2 of the committee's annual report, "Developments in Aging."

If we can assist you further, please let us know.

Sincerely,

CHARLES SWINBURN,
Deputy Assistant Secretary for Policy
and International Affairs.

Enclosure.

SUMMARY OF ACTIVITIES TO IMPROVE TRANSPORTATION SERVICES FOR THE ELDERLY [1]

INTRODUCTION

The following is a summary of significant actions taken by the U.S. Department of Transportation during 1980 to improve transportation for elderly persons.[2] The information included in the report was furnished by the Office of the

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[1] Prepared for the U.S. Senate Special Committee on Aging—January 1981.

[2] Many of the activities highlighted in this report are directed toward the handicapped. However, more than one-third of the elderly are handicapped and will benefit from these activities.

Secretary and by the following operating elements of the Department: Federal Aviation Administration (FAA), Federal Highway Administration (FHWA), Urban Mass Transportation Administration (UMTA), and National Highway Traffic Safety Administration (NHTSA). Additional information regarding UMTA actions will be submitted subsequently.

REGULATIONS

Federal Aviation Administration.—On November 13, 1980, the Federal Aviation Administration issued a notice of proposed rulemaking that would allow blind passengers to keep their canes with them while on board air carrier aircraft. The comment period for this notice closed on January 12, 1981.

Federal Highway Administration.—Under DOT's section 504 regulation, existing safety rest area facilities on the Interstate Highway System are required to be accessible to and usable by the physically handicapped, including wheelchair users, within 3 years of the effective date of the regulation (July 2, 1979). The States were requested to survey their Interstate rest areas to determine which did not meet the applicable ANSI standards and to develop a schedule for their modification to make them accessible. FHWA will continue to monitor the States' efforts to assure compliance with the ANSI standards and the States' schedules.

FHWA, in cooperation with UMTA, continued monitoring the activities of metropolitan planning organizations in meeting the elderly and handicapped "special efforts" requirements in planning transportation facilities, as set forth in regulations governing transportation for elderly and handicapped persons.

FHWA continued to monitor State compliance with section 402(b)(1)(f) of title 23, U.S.C., which provides for curb cuts at newly constructed pedestrian crosswalks, and the FHWA requirement that all new facilities on Federal-aid highways be designed to accommodate handicapped persons.

Federal Railroad Administration.—In mid-1980, Amtrak submitted to FRA its transition plan for compliance with the Department's regulation implementing section 504 of the Rehabilitation Act of 1973. The plan sets forth the various modifications necessary to make Amtrak's passenger railroad stations, vehicles, and services accessible to handicapped persons over the next 10 years. Amtrak's Board of Directors recently approved the expenditure of $2.9 million for accessibility improvements to 18 of the 23 stations scheduled for retrofit in 1981.

POLICIES AND GUIDELINES

Federal Aviation Administration.—FAA continues to work with the Air Transport Association in developing uniform procedures among airlines for transporting elderly and disabled persons. The background gained from this effort was used during 1980 to assist Civil Aeronautics Board personnel in preparing their rule implementing section 504 of the Rehabilitation Act of 1973. The CAB has indicated that the final rule will be issued in early 1981.

Investigators of aircraft accidents are continuing to feed information into FAA's Civil Aeromedical Institute computer bank on the human factors aspects of aircraft accidents and incidents. This information should prove useful to the FAA and the airline industry in the identification of special problems that are likely to be experienced by elderly and disabled persons during airline accidents.

Federal Highway Administration.—In 1979 the FHWA entered into an agreement with the Architectural and Transportation Barriers Compliance Board (A. & T.B.C.B.) to facilitate continued progress in making Federal-aid pedestrian underpasses and overpasses accessible to handicapped persons. Under that agreement, almost all States completed in 1980 an inventory of their pedestrian underpasses and overpasses constructed since 1969 with Federal-aid highway funds, to determine which facilities do not meet section 5.1 of the ANSI standards. FHWA urged States to develop a schedule for modifications of inaccessible facilities to make them accessible to handicapped persons. FHWA reviewed the results of the inventories and those schedules which had been developed by States, conducted other field reviews to further emphasize the need to construct facilities to accommodate handicapped persons and to urge States to complete their inventories.

The FHWA's rural public transportation program under section 18 of the Urban Mass Transportation Act, of 1964, as amended, has increased public transportation service in nonurbanized areas. The program has benefited the elderly both directly and indirectly. Section 18 projects are required to be coordinated with other federally funded systems, including special systems for the elderly.

To improve this coordination, FHWA issued a paper in February, issued guidelines on joint coordination with the Department of Health and Human Services in April, and issued further guidelines on coordination to its field staff.

Federal Railroad Administration.—Throughout fiscal year 1980, Amtrak continued its systemwide policy of offering a 25-percent fare discount on all one-way tickets valued above $40 to all elderly passengers.

CAPITAL ASSISTANCE

Federal Aviation Administration.—FAA obligated $1 million to its two local airports for modifications to improve access to these facilities by elderly and disabled travelers. The amount available is $550,000 for Washington National Airport and $450,000 for Dulles International Airport.

The modifications which are underway or which have been completed include: (1) Increasing the number of parking spaces for elderly and handicapped persons, (2) lowering curbs at crosswalks, (3) installation of ramps for persons who cannot use stairs, (4) installation of amplified telephones for use by persons with hearing impairments, (5) assisting with installations of TELEX for use by persons who are totally deaf, (6) provision of private toilet facilites for persons who require the assistance of attendants, and (7) placing into service a lift-equipped van for use by persons traveling between the terminal and the Metrorail station at National Airport.

Under FAA's airport development aid program, Federal and State funds in excess of $263 million have been obligated by airport operators for improving terminal facilities. A condition for accepting these grants is that improvements must incorporate the requirements of the ANSI standards.

Federal Highway Administration.—The relatively new section 18 program provided assistance for project administration, capital assistance, and operating assistance for public transportation service in nonurbanized areas. About $57 million were obligated for such activities in fiscal year 1980. This funding helped start new transportation systems and expanded others that directly benefited the elderly.

INFORMATION DISSEMINATION

Office of the Secretary.—The Department's technology sharing program finalized a summary report entitled "Transportation for the Elderly and Handicapped: Programs and Problems II." This report, which will be distributed widely early during 1981, is a companion document to an earlier literature capsule and a report on transportation programs disseminated previously through technology sharing. Other reports being finalized at DOT's Transportation Systems Center for the technology sharing program include a state-of-the-art report on small buses and overview of wheelchair restraint devices.

Technology sharing reprinted several reports during 1980 related to the topic and made them available to State and local government users: (1) "Coordination of Transportation by Human Service Agencies: An Interorganizational Perspective," January 1980, (2) "Transportation Options for the Mobility Disadvantaged in Rural Georgia," May 1979, (3) "Planning and Coordination Manual for Elderly and Handicapped Transportation Services," January 1979. Other reports relating to rural and small urban transportation were also reprinted.

Federal Aviation Administration.—FAA has distributed a 25-minute slide presentation with cassette sound track to all FAA regional offices which illustrates some of the problems disabled persons experience in traveling through airports. This audio visual presentation, released in mid-1980, assists aviation personnel in understanding problems disabled persons experience using airport terminal facilities, and solutions to these problems.

During 1980, FAA, in cooperation with the Airport Operators Council International and the Architectural and Transportation Barriers Compliance Board, completed the second printing of the third edition of "Access Travel: Airports." This guide lists 70 design features, facilities, and services available to elderly and disabled travelers at 282 airports terminals in 40 countries. Single, free copies can be obtained by writing to: Access America, Washington, D.C. 20201.

WORKSHOPS AND CONFERENCES

Office of the Secretary.—The Department served as a cosponsor of the National Miniconference on Transportation for the Elderly, endorsed by the White House Conference on Aging. The material from this session is being used to develop a technical resource document on solutions to the transportation problems of the elderly. The report, which will be distributed through the Department's technology sharing program, should be available in mid-1981.

Federal Aviation Administration.—FAA continues to conduct cabin safety workshops for airline industry personnel. During each 3-day workshop, emphasis is given to procedures for assisting elderly and disabled persons under emergency conditions. During 1980, these workshops were attended by union and management personnel, emergency procedures instructors, engineers, pilots, and technical experts representing 22 U.S. airlines, 3 foreign airlines, and Transport Canada. A total of 92 persons attended the 12 workshops held in 1980 including a special workshop held for safety representatives from the Airline Pilots Association.

Federal Highway Administration.—Under the sponsorship of FHWA's National Highway Institute (NHI), four different training courses were conducted in 1980 that included discussions of transportation problems of elderly and handicapped persons. These courses were presented for a combined total of 35 presentations. The courses were "Relocation Assistance Advisory Services," "Pedestrian and Bicycle Consideration in Urban Areas—An Overview," "Improving the Effectiveness of Public Hearings and Meetings," and "Safety Design and Operational Practices for Streets and Highways." In addition, NHI had four other courses under development for presentation in fiscal year 1981.

Urban Mass Transportation Administration.—A grant was made to Florida State University to assist in a White House Miniconference on Aging in the area of transportation. The proceedings of this conference will be used by the delegates at the 1981 White House Conference on Aging.

RESEARCH COMPLETED

National Highway Traffic Safety Administration.—The feasibility of developing a medical condition data collection system was the subject of a final report of an epidemiological study dealing with the relationship of medical conditions and driving. Because the incidence of medical conditions is much higher in older people, the study population consisted of a significant number of elderly drivers.

RESEARCH ONGOING

Office of the Secretary.—In January 1980, a study was initiated to assess progress and problems by mass transit recipients in complying with the requirements of the Department's regulation implementing section 504 of the Rehabilitation Act of 1973. Through site visits and interviews with local officials, transit operators and handicapped persons in 16 U.S. cities which have bus and/or rail transit systems, contractors examined, in particular, the process at the local level of developing transition plans for accessibility under the regulation, and the nature, status, and anticipated funding levels of proposed accessibility improvements. A final report on the study will be available early in 1981.

Federal Aviation Administration.—During fiscal year 1980, FAA designated $25,000 for the development of three projects to aid the elderly or disabled air traveler. These projects are: (a) The development of a specification for a vertical lifting device to transfer elderly and disabled persons from ground level to the aircraft passenger door, (b) an analysis of the types of assistance that must be provided to elderly persons and different classes of disabled persons, and (c) the development of performance specifications for teletypewriter equipment (TTY), airport terminal information, and directory assistance (visual and aural).

FAA's Civil Aeromedical Institute is currently analyzing biomedical factors associated with the successful escape of passengers and crewmembers and the lessons learned from accidents where escape has been either marginal or successful. Special emphasis is being given to the escape problems of handicapped travelers and the improvements in the state-of-art proposed by government and industry. Results of biomedical and engineering research on the escape problem will be published and applied to improvements in both escape systems hardware and evacuation procedures.

National Highway Traffic Safety Administration.—NHTSA awarded a contract to the National Public Services Research Institute and Texas A. & M. University to conduct an extensive evaluation of the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP) older driver training program. This program consists of a defensive driving course (DDC) originally designed by the National Safety Council for commercial drivers and modified by NRTA/AARP for the elderly driver. With a membership of 12 million and over 27,000 DDC graduates, this program provides a unique opportunity for collecting data on the particular driving problems of the elderly driver and learning what NHTSA can do to eliminate them. The final report for this project is expected to become available in July 1981.

Supported by a grant from NHTSA, Dunlap & Associates is conducting a study to investigate road accident risk levels for heart attack victims. NHTSA anticipates that this effort will provide guidelines for similar work on other medical conditions such as diabetes mellitus, seizure disorder, and glaucoma.

NHTSA is field testing three driver's manuals for novice, experienced, and older drivers in the State of Nebraska. The test involves one experimental group who will receive the new manual appropriate to his/her driving experience and age, and two control groups. (One group will receive the current State driver's manual and the other will receive no manuals at all.) NHTSA hopes this test will show an accident reduction rate as a result of presenting more relevant information to the driving applicant. If it does, NHTSA will have found a virtually no-cost countermeasure, since States routinely distribute manuals to driver license applicants.

Urban Mass Transportation Administration.—A grant was made to Dayton, Ohio, to test several methods of collecting data on the geographic distribution of elderly and handicapped persons. The results of these tests will be disseminated to metropolitan planning organizations and transit authorities in 1981.

A grant was made to Norfolk, Va., to document a unique planning process developed by that city's metropolitan planning organization and the United Way. This process provides for the utilization of taxis and social service agencies in providing transportation for elderly and handicapped persons.

Two cities, Pittsburgh, Pa. and Phoenix, Ariz., will test a previously developed manual on phasing full-size accessible buses into regular transit service. Such things as disruption of service and maximum benefits to handicapped persons will receive particular attention.

Jointly with the Department of Health and Human Services, a state-of-the-art report was developed on training handicapped persons to use transit.

DEMONSTRATIONS

Office of the Secretary.—FHWA and UMTA, with OST technical support and monitorship, are supporting a six-State demonstration on simplification of billing and accounting requirements for social service and public bus systems. The States involved are South Carolina, North Carolina, Michigan, Massachusetts, Iowa, and Arkansas. The Department of Health and Human Services (HHS) is also supporting the project.

Federal Highway Administration.—The 4-year pedestrian safety demonstration project is continuing in the Commonwealth of Puerto Rico. This project specifically recognizes that older persons are overrepresented in pedestrian fatality statistics, and will include an evaluation of measures to enhance the safety of older pedestrians. A study entitled "Priority Accessible Networks" is validating a user's manual of the same title. This manual is designed to offer guidance to local persons involved in developing a transportation network for elderly and handicapped pedestrians. Details on the design of individual elements of such networks are also included.

FHWA is also sponsoring a demonstration in Vermont to improve coordination between nonurbanized public, social service, and intercity bus transportation.

Urban Mass Transportation Administration.—UMTA amended and extended grants which support the Lawrence, Mass., user subsidy and the Pittsburgh, Pa., transportation brokerage demonstrations.

A cooperative agreement with the Department of Health and Human Services will result in a study of insurance problems of social service agency transportation providers.

The following is a list of relevant new demonstration grants made:

—Chico Calif., for a user subsidy demonstration.

—San Diego, Calif., to plan a social service coordination demonstration.

—Pasadena, Calif., to plan a brokerage paratransit system.

ITEM 13. DEPARTMENT OF THE TREASURY

JANUARY 15, 1981.

DEAR LAWTON: In response to your and Senator Domenici's request, I am pleased to submit the Treasury's report on activities during 1980 which affected the aged. I hope this information will be useful both to the committee and to others concerned with the welfare of older Americans.

Best wishes.

Sincerely,

G. WILLIAM MILLER, *Secretary.*

Enclosure.

TREASURY ACTIVITIES IN 1980 AFFECTING THE AGED

The Treasury Department recognizes the importance and special concerns of older Americans, a group comprising a growing proportion of the population.

In the area of economic policy, the Treasury has been involved in the development and implementation of administration policies to fight inflation, which strikes particularly hard at retired persons living on fixed income. The Secretary, as managing trustee of the social security trust funds, is also concerned with preserving the financial soundness of social security, a major source of income to persons over the age 65.

The agency of the Treasury with whom the greatest number of older Americans have contact is the Internal Revenue Service (IRS). Special activities of the IRS directed at helping persons age 65 and over are detailed in the next section. Activities of other Treasury agencies which affect older Americans are summarized in the last section of the report.

INTERNAL REVENUE SERVICE ACTIVITIES AFFECTING THE AGED

The Internal Revenue Service places considerable emphasis on informing older Americans of their tax rights and responsibilities. IRS also continues to make a special effort to inform these individuals who, because of immobility, impaired health, or any of several other factors, may miss out on some tax benefits to which they are entitled unless IRS reaches them directly.

During 1980, IRS expanded assistance to older Americans through the tax counseling for the elderly (TCE) program. Training for TCE volunteers emphasized tax problems of the elderly. Lessons included information on tax credits for the elderly, estimated tax payments, and pension income.

In addition, IRS issued a number of informational materials targeted towards older Americans. Those materials had the following themes:

—Single taxpayers aged 65 and over are not required to file a Federal income tax return unless their income for the year was $4,300 or more (as contrasted with $3,300 or more for a single taxpayer under age 65). Married taxpayers who could file a joint return are not required to file unless their joint income for the year was $6,400 or more, if one of the spouses was 65 or over, or $7,400 or more if both were 65 or over. This is because all taxpayers age 65 or over get an extra personal exemption of $1,000. (See Publication 554 for further information.)

—The special tax credit for the elderly enables persons over 65, and also persons under 65 who had pension or annuity income from a public retirement system, to reduce their taxes by as much as $375 if single, or $562.50 if married filing a joint return. (See Publication 524.)

—The entire gain on the sale of a house before July 27, 1978 can be excluded from income if the selling price is $35,000 or less. For selling prices above $35,000, a part of the gain is excludable. For houses sold after July 26, 1978, those age 55 and over are allowed a once-in-a-lifetime exclusion of up to $100,000 of gain on the sale. (See Publication 523.)

—Much of the income received in retirement years is free from Federal income tax. This includes social security payments, railroad retirement benefits, payments from a general welfare fund, and payments for blindness. (See Publications 567 and 575.)

—Retirees with taxable pension income can avoid paying estimated tax or receiving a large tax bill at the end of the year by filing Form W-4P authorizing the payer of the pension to withhold taxes from the pension payments.

—Tax issues of particular interest to handicapped and disabled people are covered in a new pamphlet, Publication 907.

All publications are available free of charge at IRS offices. They are also used extensively in taxpayer education programs, often in cooperation with organizations especially interested in problems of retired people. In addition, IRS personnel provide such services as free tax information by mail, free telephone assistance, walk-in service at many IRS offices, and temporary offices during the filing season.

To communicate tax information of interest to the elderly, the IRS used the print and broadcast media, specialized newsletters, and organizations serving older Americans:

—To publicize the new tax counseling for the elderly (TCE) program, in which nonprofit organizations provide free tax information and assistance to individuals age 60 and over, the IRS produced a 12½-minute film, "A Right Good Thing." The film, which describes tax situations, frequently experienced by the elderly and depicts how the older taxpayer can get assistance at a local TCE site, is available free of charge to any interested group or organization.

—Also, to publicize TCE and other tax benefits for the elderly, two filing-season TV and three radio spots were produced as well as a drop-in ad for distribution to magazines, and a taxpayer information materials (TIM) package containing featurettes, news releases, newsletter items, a question and answer column, a live copy radio spot and a 2-minute radio program.

—Two filmed television public service announcements (PSA) were produced and were sent to each of the three major networks and approximately 1,000 television stations nationwide. Statistics from Broadcast Advertisers Reports, a firm which tracks the play of commercials and PSA's, indicate that these "Benefits for Older Americans" PSA's were used extensively.

—Three recorded radio PSA's were sent to the major networks and to about 6,700 local radio stations. Live copy radio material provided to these outlets was also widely used.

—Materials for the print media were provided to newspapers, periodicals and newsletters nationwide. Print materials also were sent to senior citizen and retirement organizations such as the American Association of Retired Persons, National Council of Senior Citizens, National Retired Teachers Association, and to State offices of services for the aging. A newspaper supplement with an article geared toward older Americans was sent to 4,500 local newspapers.

—Our inspectors made speeches to senior citizens groups to warn them of fraudulent schemes to victimize the elderly, including methods used by unscrupulous tax preparers. During fiscal year 1980, inspectors arrested an individual who posed as an IRS employee to obtain money and property from senior citizens.

The IRS assisted various governmental agencies in their administration of the Age Discrimination in Employment Act as it pertains to employee retirement plans. These agencies include the Department of Labor, the Pension Benefit Guaranty Corporation, and the Equal Employment Opportunity Commission.

Regulations and Rulings Activities

During 1980 proposed regulations under IRC section 37 were issued relating to the income tax credit for the elderly (2–27–80). Final regulations are expected to be adopted by the end of 1980. Also, final rules were adopted relating to tax counseling for the elderly (1–29–80).

In 1980, the IRS published the following revenue rulings generally affecting senior citizens:

(1) Rev. Rul. 80–45, 1980–8 I.R.B. 7, holds that unreimbursed expenses for transportation, paper and pencils, newspaper advertising, and similar items incurred by volunteers in connection with their participation in the volunteer income tax assistance (VITA) program are deductible under section 170 of the Code.

(2) Rev. Rul. 80–172, 1980–27 I.R.B. 7, holds that a taxpayer who otherwise meets the requirements of section 121 of the code may make the election to exclude gain on the sale of a personal residence if the ownership and use tests are met, even though the tests are not met simultaneously.

(3) Rev. Rul. 80-248, 1980-37 I.R.B. 10, pertains to interests on "reverse mortgage loans." The primary purpose of such loans is to enable elderly persons with limited income to remain in their homes. The ruling holds that interest which is added monthly to the outstanding loan balance as it accrues is neither includible in a cash method lender's gross income nor deductible by a cash method borrower at the time it is added.

(4) Rev. Rul. 80-249, 1980-37 I.R.B. 11, holds that, where a taxpayer who realized a gain on the sale of a principal residence elected to exclude the gain under section 121 of the code and elected to use the installment method of reporting income from the sale, in determining the amount of each installment payment that is reportable under the installment method of accounting, gross profit in the formula provided in section 453(a)(1) is the amount of the gain that is not excludable from gross income.

(5) Rev. Rul. 80-325, 1980-59 I.R.B. 6, supersedes Rev. Rul. 63-167, 63-168, and 63-169, relating to the effect of community property laws on the computation of retirement income credit for a social security beneficiary, a civil service retiree, and an armed forces retiree, with respect to the tax credit for the elderly in the case of a joint return filed for a taxable year beginning after December 31, 1977, because section 37(e)(8) of the code, which applies to taxable years beginning after December 31, 1977, provides that section 37(e) applies without regard to community property laws in the case of a joint return.

(6) Rev. Rul. 80-340, 1980-50 I.R.B. 8, holds that the extra cost of a specially equipped television set that provides deaf individuals with a visual display of the audio portion of television programs and the cost of an adaptor for a conventional television set that performs the same function are medical expenses.

The following rulings pertain to employee retirement plans:

(1) Rev. Rul. 80-27, 1980-1 C.B. 85, holds that retirement benefits being paid to a retiree can, by court order, be reallocated and paid as alimony or support to the retiree's spouse, former spouse, or dependent children without adversely affecting the tax qualified status of the plan. This has the effect of enforced sharing of retirement incomes with spouses that otherwise might not be able to provide for themselves. The elderly are particularly vulnerable when there is a family separation and withdrawal of financial support by the working or retired spouse. Consequently, this ruling is of considerable significance to them.

(2) Rev. Rul. 80-128, 1980-1 C.B. 86, provides that an employee of two corporate employers, whose separate qualified plans were funded by contributions to a single trust, may terminate employment with one of the employers and receive a lump-sum distribution. This holding has particular relevance to the aged because they are susceptible to physical impairments that eventually discourage continued multiple employment but would likely have an immediate need for supplemental income prior to the time of full retirement.

(3) Rev. Proc. 80-17, 1980-1 C.B. 621, sets out rules of procedures for sponsors of prototype simplified employee pensions (SEP). SEP's were made available in 1979 to encourage retirement contributions by employers for the benefit of their employees. Prototype SEP's will be reviewed by the Service to ensure technical accuracy. Diversity among prototype SEP's will provide a wide selection of statutorily allowable features. Unlike individual retirement accounts, SEP's have a much higher contribution limitation ($7,500 versus $1,500), and are available for employees over age 70½. The impact of these kinds of easily administered and inexpensive retirement programs should be to increase the level of retirement funds available to senior citizens.

(4) Rev. Rul. 80-122, 1980-1 C.B. 84, adds a measure of flexibility for plans which provide that benefit payments may be suspended for a period during which a former retiree returns to work. This could also benefit the employee who may thus be able either to increase the ultimate retirement benefit or prolong the benefit payments. Validation of this kind of plan provision may also have the effect of encouraging companies to rehire former employees who find employment preferable to retirement.

(5) Notice 80-7, 1980-1 C.B. 578, makes procedures available to salvage plans that do not meet the requirements for tax qualified status. In order to obtain full reinstatement, such plans must provide contributions and benefits (to all those who would have been eligible if the plan had conformed to the requirements from the beginning) at levels required by the code. Because this program will potentially impact on about 30,000 plans, it will have the effect of increasing retirement incomes for substantial numbers of present and future older citizens.

(6) Rev. Rul. 80-276, 1980-42 IRB 6, provides reassurances that profit-sharing plans may continue to provide that participants can receive distribution of benefits at a stated normal retirement age of less than 65 years, even if the participant does not actually retire. The result is that the employee of such a plan can have a more gradual retirement transition.

Forms Activities for the Elderly

A highlight has been added to the 1980 packages and instructions for Forms 1040 and 1040A to alert retirees that they may need to make estimated tax payments and thereby avoid any penalties for underestimation of estimated tax.

The instructions for Form W-4P, Annuitant's Request for Federal Income Tax Withholding, have been revised to caution taxpayers that they may be subject to estimated tax penalties if not enough tax is withheld or paid by estimated tax on taxable pensions and annuities.

OTHER TREASURY ACTIVITIES AFFECTING OLDER AMERICANS

Other agencies of the Treasury may have an impact upon the aged as part of their specific functions. Developments during 1980 include:

—The Treasury supported legislation to phase out Regulation Q, an interest rate ceiling on deposits in financial institutions. While large depositors can achieve near-market interest rates by purchasing money market certificates ($10,000 minimum denomination), small depositors, often the elderly, are limited to a 5¼ percent passbook interest rate (5½ percent for depositors at thrift institutions). Small depositors are likely to receive more equitable interest rates by phasing out Regulation Q. The President signed this legislation (Depository Institutions Deregulation and Monetary Control Act) on March 31, 1980.

—The Treasury continued its expansion of the direct deposit program for Federal recurring payments. This program offers an added measure of convenience and security to many people, including retirees, who depend on regular Government checks by permitting direct deposits into a personal checking or savings account. The service was implemented in 1975 and now includes social security benefit, supplemental security income, civil service retirement, railroad retirement, Veterans Administration compensation and pension payments, and certain Federal salary payments. As of December 1980 over 12.6 million recipients have enrolled in the program, representing over 28.6 percent of total recipients. Since 1977, a nationwide educational campaign has been underway to inform recipients about the advantages of the program. Treasury's goal is to have 55 percent of all eligibile recipients enrolled in the program by 1985 and 80 percent by 1990.

—The Treasury also continued to protect elderly recipients of Government payments through the vigilance of the Secret Service. During fiscal year 1980, the Service closed 15,407 social security check forgery cases and 5,581 supplemental security income forgery cases. Most of these checks were issued to retirees. Approximately 64 percent of the checks were cleared, that is, the identity of the forger discovered.

Finally, the Department of the Treasury makes every attempt to participate in the governmentwide effort to end discrimination against particular groups, including the aged, in employment and in the accessibility of public information and facilities:

—Throughout the Department's facilities, architectural modifications and new buildings include ramps, security bars in restrooms, and other aids to insure that Treasury facilities are usable by all individuals, including the elderly handicapped.

—In employment, Treasury Offices and Bureaus have implemented a part-time employment program (PTEP) as a result of Public Law 93-437 (October 10, 1978). Implementation of the program includes a particular focus on special interest groups such as organizations of older people. The PTEP is a viable and effective vehicle through which retirees and the elderly can obtain meaningful and valuable employment. The employment of the elderly benefits both the individual by supplementing his or her financial intake and the agency by the addition of productive employees to the regular work force.

—A retirement planning seminar was presented to approximately 550 Treasury employees in the Washington, D.C., metropolitan area. The seminar, consisting of three 4-hour sessions, was designed to assist employees in pre- and postretirement financial, housing, health, and life pursuit planning. Similar seminars are offered by the Philadephia Mint and will be available throughout the Bureau of the Mint in succeeding fiscal years.

OFFICE OF REVENUE SHARING ACTIVITIES AFFECTING THE AGED

GENERAL REVENUE SHARING PROVISIONS AFFECTING THE AGED

The general revenue sharing program is a direct general fiscal assistance program that provides funds to State and local governments. No application is required of State and local jurisdictions to receive these moneys, although a statement of assurance of compliance with the revenue sharing law is required. Therefore, revenue sharing is described best as an entitlement program.

Congress created the program in 1972 with the intent of sharing Federal income tax with State and local governments. Legislative provisions of the program indicate an intent to disburse these funds with minimum restrictions on the use of funds and allow maximum flexibility by State and local officials in determining how they spend the money.

The State and Local Fiscal Assistance Act of 1972 (Public Law 95–512) was authorized for a period of 5 years to end in December 1976. However, the program was extended first under the 1976 amendments (Public Law 94–488) through September 30, 1980, and extended a second time in December 1980 under Public Law 96–604 through September 30, 1983. For the respective periods, a total of $74 billion will be distributed to State and local jurisdictions based on a formula prescribed by the Revenue Sharing Act.

Originally, State and local governments were required to use the funds in priority categories contained in the act. Under the 1976 amendments, the funds may be used for any purpose which is a legal use of the jurisdiction's own funds under State and local law. Thus, recipients are to this extent free to use shared revenues for expenditures of benefit to the aged.

Extension of the program in 1976 brought a number of substantive changes from the original act, which became effective January 1, 1977, and remain primarily intact under the 1980 amendments. Among the 1976 amendments are the following changes which could be viewed as affecting elderly persons. Specifically, the 1976 amendments:

—Strengthened the nondiscrimination requirements to include specific protection against age discrimination. This provision, which became effective July 1, 1979, does not apply to employment discrimination.

—Provided for special public participation requirements relative to the participation of citizens in the decisions on expenditure of GRS funds and encouraged recipient governments to include senior citizens in this process.

—Repealed the provisions which restricted the use of funds to certain priority expenditure categories. Eliminated the prohibition against the use of revenue sharing funds as local matching money for Federal grants.

The removal of the prohibition against using GRS funds as matching money for Federal grants may have increased the availability of funds for use in the social services areas.

GRS contributions to aged Americans are likely to be found primarily in the areas of public participation and nondiscrimination. Activities in these areas which may increase the accessibility and accountability of governments to the aged as a special class are:

—Publication of the proposed age and handicapped discrimination regulations in December 1979.

—Publication in January 1981 of the final regulations with respect to a qualified handicapped individual. These regulations address service delivery, employment, and accessibility of programs to the handicapped.

—The delay in publication of ORS's final age discrimination regulations is due to OMB's failure to approve the recordkeeping requirements as set by HHS's governmentwide regulations. Nonetheless, ORS is currently enforcing the age discrimination regulations of 1975 by authority of 45 CFR, part 90, pending OMB approval of its own regulations.

—Participation by ORS in two major workshops on sec. 504 of the Rehabilitation Act of 1973. These workshops were sponsored by the National League of

Cities and the U.S. Conference of Mayors, and provided an opportunity for the Office of Revenue Sharing to inform mayors, city managers, and other city officials about the handicapped provisions of the Revenue Sharing law.

The Office of Revenue Sharing continues to conduct outreach activities to groups requesting assistance in program interpretation. It also follows up on all complaints filed with it.

HIGHLIGHTS OF 1980

A considerable effort was expended during the fiscal year on trial computer runs and other activities concerned with the renewal of general revenue sharing. Testimony was offered before both Houses of Congress and substantial materials were supplied to them. At the end of the fiscal year, the Congress was still considering renewal.

During fiscal 1980, increased emphasis was placed on followup reviews of State audit agencies whose performance had been determined to be unacceptable. By the end of the year all of the State audit agencies had either achieved an acceptable status or the recipients involved had arranged to have their audits performed by independent public accountants. By the end of fiscal 1980, 19,554 audit reports had been submitted to the Office of Revenue Sharing or to appropriate State audit agencies.

The number of civil rights complaints continued to increase during this fiscal year, with 1,236 cases carried over into fiscal 1981.

More than 200 public participation complaints were received in fiscal 1980; 199 cases were closed during the year.

Public Participation

The 1976 amendments to the Revenue Sharing Act require each State and local government to conduct two public hearings prior to appropriating revenue sharing funds. The function of the hearings is to provide the public with the opportunity to suggest possible uses for the funds and to comment on uses proposed by elected officials. Public notice of the hearings and the availability for public inspection of budget documents and revenue sharing use reports are integral to this process.

Investigations were undertaken of more than 200 recipient governments to assure compliance with the public participation requirements; 199 cases were closed during the fiscal year. Direction was provided to those jurisdictions which failed to comply in order to enable them to take voluntary corrective action. The compliance efforts of five jurisdictions were reviewed following completion of the initial investigation to provide technical assistance where needed.

Outreach activities were carried out to advise members of nationwide community interest organizations of the opportunities for public participation in the revenue sharing program. The public participation staff participated in the national conventions of seven community interest organizations. The operations of the Office of Revenue Sharing were described at the conventions and public participation publications were distributed.

Technical Assistance to Recipient Governments

The Office of Revenue Sharing provides information and technical assistance concerning the program to State and local governments receiving general revenue sharing funds.

Technical assistance was provided to recipients through more than 2,800 letters in response to written requests for specific information and guidance. In addition, thousands of telephone contacts were made with recipient governments, various organizations, and others interested in the revenue sharing program. Eight technical papers have been prepared on various aspects of the program.

The Office has established a network of about 600 liaisons within the 50 States. Over 70 technical assistance workshops were conducted during the year for the benefit of recipient governments, in cooperation with these liaisons and other cosponsors.

Quarterly, each of the more than 39,000 recipient governments was sent an informational letter to help them comply with public participation and other requirements of the program.

Civil and Human Rights

Section 122 of the Revenue Sharing Act provides that: "No person in the United States shall, on the grounds of race, color, national origin, or sex, be excluded from participation in, be denied the benefit of, or be subjected to discrimination under any program or activity of a State government or unit of local government, which government or unit receives funds * * *. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with respect to an otherwise qualified handicapped individual as provided * * * shall also apply to any such program or activity. Any prohibition against discrimination on the basis of religion, or any exemption from such prohibition, as provided * * * shall also apply to any such program or activity."

Although the Civil Rights staff is small, it has investigated a significant number of complaints, many of which have been closed through negotiation and voluntary compliance. In those instances where recipient jurisdictions have been reluctant to take the necessary steps to comply with civil rights requirements, ORS has initiated action requiring them to do so.

Shown below is a table that demonstrates the growth of the activities of the Civil Rights Division.

DISCRIMINATION COMPLAINTS

Year	Received	Discrimination/ findings	Closed	Carried over
1972	2	0	0	2
1973	27	1	2	27
1974	75	14	26	76
1975	213	8	29	260
1976	229	7	71	418
1977	276	125	142	552
1978	306	156	184	674
1979	330	179	228	776
1980	677	151	217	1, 236

The Office continued to work in a cooperative effort with several Federal agencies to help resolve discrimination complaints and to assist in conducting field investigation. The Office is attempting to renegotiate cooperative agreements with the Federal agencies with which it had shared agreements under the 1972 Revenue Sharing Act.

Preparation of a more extensive civil rights compliance manual for processing complaints is in progress and should be completed in fiscal 1981.

Audit Procedures

The 1976 amendments to the Revenue Sharing Act require each recipient government receiving $25,000 or more annually in revenue sharing entitlements to have an independent audit of its financial statements in accordance with generally accepted auditing standards, not less often than once every 3 years, to determine compliance with the act. This requires a financial audit of all funds and a compliance audit of revenue sharing and antirecession fiscal assistance funds. The audit requirements are applicable to about 11,000 of the nearly 38,000 revenue sharing recipients. At the end of the 1980 fiscal year 64 percent of the recipient governments subject to the audit requirements had fully complied. Table 1 shows the status of all governments which must be audited. All but 5 percent of these governments filed audit reports or acceptable audit plans with the Office of Revenue Sharing by the end of the fiscal year.

There are 63 State audit agencies involved in auditing State and local governments (some States have a separate audit agency responsible for auditing the State accounts and another agency responsible for local governments.) ORS reviewed the professional practices of all State audit agencies in previous fiscal years and found 20 of the agencies to be performing unacceptable audits for revenue sharing purposes. During the 1980 fiscal year, emphasis was placed on performing followup reviews of the unacceptable agencies to determine whether progress had been made in correcting the deficiencies.

In addition to the reviews of State audit agencies described above, the fiscal year's major emphasis was placed on the review of audit reports submitted by recipient governments. By the close of the fiscal year, 19,550 audit reports had been submitted to the Office of Revenue Sharing or to State audit agencies by 9,627 recipient governments. (In many instances a government is required to submit more than one report in order to cover "all of its funds" as required by the act.) Of the reports submitted, 13,735 were received in 1980 with approximately one-half of them being submitted directly to ORS. The reports reviewed by ORS and State audit agencies during the current fiscal year resulted in 5,413 governments satisfying the audit requirements during fiscal 1980.

TABLE I.—GENERAL REVENUE SHARING AUDIT REPORTS STATUS RECAP, SEPT. 30, 1980

Status category	Number of governments	Percent
1. Total governments subject to audit	10,946	100
2. Fully acceptable	6,956	64
3. Partially acceptable [1]	1,209	11
4. Unacceptable	109	1
5. Unauditable	14	
6. Not reviewed [2]	1,339	12
7. Governments filing audit reports (total lines 2 through 6)	9,627	88
8. Audit plan filed [3]	783	7
9. Total (lines 7 and 8)	10,410	95
10. Delinquent governments [4]	536	5
11. Total (lines 9 and 10)	10,946	100

[1] Governments that have filed either a financial or compliance report that has been accepted; second report pending. Also includes governments with partial audit submissions.

[2] Governments that have submitted reports to State audit agencies or ORS and the reports have not been reviewed as of the report date.

[3] Governments that have not filed audit reports but have filed acceptable plans for submitting the report.

[4] Governments that failed to respond to the audit requirement or responded by filing plans and then failed to meet the plan dates.

TABLE II.—OFFICE OF REVENUE SHARING, AUDIT DIVISION WORK MEASURES, THROUGH SEPT. 30, 1980

Noncompliance cases	Fiscal year— Through 1976	1977	1978	1979	1980	Cumulative through 1980
Revenue sharing:						
Balance beginning of period		265	390	178	102	
Cases opened	779	495	364	183	111	1,932
Total	779	760	754	361	213	1,932
Cases closed	514	370	576	259	126	1,845
Balance end of period	265	390	178	102	87	87
Antirecession:						
Balance beginning of period				16	39	
Cases opened		4	35	69	39	147
Total		4	35	85	78	147
Cases closed		4	19	46	49	118
Balance end of period		0	16	39	29	29

Copies of audit reports must be submitted to ORS if they disclose violations of Revenue Sharing or Antirecession Fiscal Assistance Acts and regulations. Copies of audit reports issued by independent public accountants (IPA's) for which a State auditor has no legal responsibility must also be furnished to IRS. State auditors provide ORS with a quarterly report listing audit reports which they issue or receive for review from IPA's that do not contain violations of the Revenue Sharing or Antirecession Fiscal Assistance Acts or regulations. These reports are kept on file by the State auditors for review by the Audit Division as a part of the periodic reviews made of State auditors' technical performance.

In fiscal 1980, 111 noncompliance cases were opened of which 98 resulted from findings contained in audit reports. Cases closed totaled 126. Thus, open cases were reduced from 102 to 87 or a decrease of 15 during the year. As of September 30, 1980, there were only 17 cases that had been open for a year or more. See table II for a summary of noncompliance case activity.

The Audit Division also responded to 4,207 requests from IPA's for confirmation of entitlement fund payments.

Legal Issues

In fiscal year 1980, the Chief Counsel for the Office of Revenue Sharing (ORS) represented the Director and the Office in the Federal court systems and at administrative hearings; negotiated and supervised the execution of compliance agreements; drafted legislation and administrative regulations for implementation of handicap discrimination requirements; and continued to provide daily legal counsel to the Director and the Divisions of the ORS on a variety of issues.

On July 10, 1980, in *Board of Supervisors of Henrico County* v. *Blumenthal* (CA 79–1788), the Fourth Circuit Court of Appeals reversed a lower court ruling, and held that the ORS procedure of computing adjusted taxes was lawful in that it was reasonably related to the purposes of the Revenue Sharing Act. The court held that the ORS was under no obligation to revise its bookkeeping system to make accommodations for individual recipient governments. A petition for rehearing was denied by the court.

The Chief Counsel is providing legal representation in several cases in U.S. district court in which the ORS is a defendant.

In addition to litigation in the Federal courts, the Office of the Chief Counsel has prosecuted cases on the administrative hearing level. The majority of these concern civil rights violations under the act. In *ORS* v. *Borough of Haledon, N.J.*, the Director has for the first time appealed an administrative law judge's finding of no sex discrimination to the Secretary of the Treasury.

During this fiscal year, the Office of the Chief Counsel has assumed responsibility for prosecuting civil rights cases arising from holdings by State or Federal judges, in which jurisdictions have unlawfully discriminated. The Office has pursued these actions, issuing numerous notices of noncompliance and suspending funds where no compliance was obtained.

The Chief Counsel drafted regulations under the act which for the first time include age and handicap discrimination. Proposed legislation to extend the revenue sharing program and the antirecession fiscal assistance program was also drafted on behalf of the Secretary.

Data Acquisition and Analysis

The Office of Revenue Sharing has evaluated the effects of proposed formula changes on the distribution of general revenue sharing funds. This information has assisted the Department of the Treasury and the appropriate congressional committees in developing proposed changes in the General Revenue Sharing Act.

The Office of Revenue Sharing began planning with the Bureau of the Census to obtain population estimates for Indian tribes and Alaskan Native villages. The results of the 1980 census should permit the development of population counts for Indian tribes and Alaskan Native villages. It is expected that population estimates as of July 1, 1981, for Indian tribes and Alaskan Native villages as well as for all other recipient governments will be prepared by the Census Bureau for future entitlement periods.

The accuracy of the individual data factors used in the computation of entitlements is of major importance. These data factors—per capita income, adjusted tax collections, population, and intergovernmental transfer revenues—are obtained from several sources, including the Bureau of the Census, the Bureau of Economic Analysis, the Bureau of Indian Affairs, and the Internal Revenue

Service. In recognition of the importance of accurate data upon the equity of funding under the program, the Office of Revenue Sharing has traditionally placed major emphasis upon efforts to insure their validity.

In past years, the Office has conducted a data improvement program whereby all eligible recipient governments are advised of the individual data factors to be used in the computation of their allocations for the forthcoming entitlement period. Each government was asked to examine its data factors based upon established data definitions, and to propose corrections if appropriate. Typically, several thousand revisions may result from a single data improvement program.

Under normal circumstances, such a program would have taken place in the spring of 1980, for a not-yet authorized entitlement period 12. However, due to the uncertainties of renewal, plans for a full-scale data improvement program were postponed until legislative changes resulting from renewal could be evaluated and conveyed to all recipient governments.

At the beginning of fiscal year 1980, approximately 2,000 governments had failed to provide essential data to the Bureau of the Census relating to adjusted taxes and intergovernmental transfer revenues despite several collection attempts. With the Office of Revenue Sharing assuming responsibility for their collection at that point, reports were obtained from more than 1,200 previous nonrespondents in time for inclusion in the final 11th period allocations. Also, challenges submitted in response to that period's data improvement program were accepted through the end of fiscal year 1980, as provided by statute. Since the beginning of fiscal year 1980, approximately 200 such challenges were received and acted upon by the Office.

In preparation for a possible renewal of the revenue sharing program in essentially its present form, the Office obtained updated data factors. These data consist of population estimates relating to July 1, 1978; estimates of per capita income for calendar year 1977, and adjusted taxes and intergovernmental transfers amounts relating to the local government fiscal year which ended between July 1, 1978, and June 30, 1979. These data have been subjected to rigorous analysis within the Office of Revenue Sharing and the Bureau of the Census, and are expected to be used in a data improvement program for entitlement period 12.

Uses of Funds

The State and Local Fiscal Assistance Act of 1972, as amended, and regulations promulgated under title II of the Public Works Employment Act of 1976, as amended (Antirecession Fiscal Assistance), require each State and local government which receives funds to supply information on its annual fiscal transactions, including data on the expenditure of funds received through either of these programs. A report has been published on the data submitted by the State and local governments entitled, "Expenditures of General Revenue Sharing and Antirecession Fiscal Assistance Funds 1977–1978." It presents the data aggregated by type of government. In addition, individual government data are presented for all States, for the 63 largest counties, and for the 46 largest muncipalities.

The following table summarizes the reported expenditures of GRS money by State and local governments for 1977–78 by functional categories, as reported by these governments to the Bureau of the Census. These reports provide only a limited basis for making judgments about the impact of shared revenues since displacement effects are not fully revealed.

The total revenue sharing expenditures of over $6.5 billion in 1977–78, represent expenditures reported by more than 38,000 State and local governments. According to reported data, over 22 percent of shared revenue spent during the period went into public safety activities such as fire and police protection services. The next category on which most revenue sharing funds were reported to have been expended is education which accounted for over half of all revenue sharing expenditures by State governments in 1977–78. In general, the reported expenditure patterns by functional categories have remained the same as those of previous periods.

Of the total amount of revenue sharing expenditures, about 75 percent was reported as being used to augment and maintain current expenditures, while 23 percent were reported as devoted to capital outlay. The remainder of less than 2 percent was reported as used for debt redemption.

TABLE 8.—EXPENDITURE OF GRS FUNDS BY FUNCTION: 1977–78

[Dollar amounts in thousands]

Function	GRS	
	Amount	Percent
Total	$6,682,324	100.0
Correction	173,266	2.6
Education	1,230,911	18.4
Finance and general administration	274,845	4.1
Fire protection	507,614	7.6
Health	426,956	6.4
Highways	849,855	12.7
Hospitals	204,379	3.1
Interest on general debt	112,335	1.7
Parks and recreation	257,655	3.9
Police protection	956,338	14.3
Public welfare	223,628	3.3
Redemption of debt	110,266	1.7
Sanitation other than sewerage	275,495	4.1
Sewerage	79,453	1.2
Utility systems	67,300	1.0
All other	932,028	13.9

The Revenue Sharing Organization

The staff is organized into nine functional units, as follows:

(1) Administrative services staff—Coordinates personnel, daily financial operations, central services, and other internal administrative functions of the Office.

(2) Planning and coordination staff—Accomplishes special research projects at the request of the Director; manages the program planning system, and coordinates budgetary matters.

(3) Data and Demography Division—Responsible for acquisition of current and accurate data used to compute allocations of funds; conducts data improvement program.

(4) Systems and Operations Division—Computes allocations of funds; writes payment vouchers; completes all associated accounting; develops management information systems; issues and processes required reports; produces computer-generated communications and publications and carries out allocation trials related to policy development.

(5) Audit Division—Reviews the practice and audits made by State audit agencies, certified public accountants, and other public accountants; follows up on audit compliance situations.

(6) Civil Rights Division—Responsible for insuring compliance with the civil rights provisions of revenue sharing and antirecession law; conducts investigations of allegations of noncompliance; and cooperates with other Federal agencies, and State governments.

(7) Intergovernmental Relations and Technical Assistance Division—Provides technical advice and assistance to States and local governments; maintains liaison with public interest groups; and through a separate branch enforces the public participation provision of the Revenue Sharing Act, as amended.

(8) Public affairs staff—Provides information about general revenue sharing to the public, the media, citizens' groups, other Federal agencies, and the Congress.

(9) Chief Counsel—Interprets the law; issues opinion letters, prepares regulations; represents the Office of Revenue Sharing in all legal matters concerning the general revenue sharing and antirecession fiscal assistance programs.

At the end of the fiscal year, the Office of Revenue Sharing employed approximately 150 permanent employees and operated at a cost of about $6,460,048.

MAJOR EVENTS: A CHRONOLOGY

January 8, 1980

The first payment of revenue sharing entitlement period 11 funds was made to 35,034 State and local governments. A total of $1.7 billion was paid.

April 7, 1980

The second quarterly payment of entitlement period 11 revenue sharing funds was issued to 36,428 State and local governments. A total of $1.7 billion was paid.

July 8, 1980

The third quarterly payment of revenue sharing funds for the 11th entitlement period was issued to 36,511 units of State and local governments. A total of $1.7 billion was paid.

October 7, 1980

The fourth quarterly payment of revenue sharing entitlement period 11 was issued to 36,857 State and local governments. A total of $1.7 billion was paid.

TRUST FUND STATUS

State and Local Fiscal Assistance Trust Fund

The State and Local Fiscal Assistance Act of 1972 (Public Law 92-512) established in the Treasury of the United States a trust fund to be used only for payments to States and local governments as provided in the act. The 1976 amendment (Public Law 94-488) to the original act of 1972 extended the general revenue sharing program from January 1, 1977, through September 30, 1980. The original act appropriated to the trust fund approximately $30.2 billion to be distributed in seven periods. The amendments extending the general revenue sharing program provide, within specified maximum limits, for the determination of entitlement period appropriations beginning with period 8 by the use of a statutory formula. Funds appropriated for distribution by the original and amended act (periods 1-7 and 8-11 respectively) are as follows:

	Start	End	Amount
Entitlement period (EP):			
1-7	January 1972	December 1976	$30,212,530,000
8	January 1977	September 1977	4,987,500,000
9	October 1977	September 1978	6,850,000,000
10	October 1978	September 1979	6,850,000,000
11	October 1979	September 1980	6,850,000,000

In addition to the above, amounts are appropriated for "noncontiguous States adjustments" ($42.3 million for EP 1-11) which are available for allocation to Alaska and Hawaii under prescribed conditions. These amounts are distributed only to the extent required pursuant to section 106(c) of the act as amended, and any unused amounts must be returned from the trust fund to the general fund of the Treasury.

To insure the integrity of the trust fund and to eliminate the prospect of recurring computations of entitlements of all 39,000 governments for prior entitlement periods, the Office of Revenue Sharing has established obligated adjustment reserves. During the seven periods covered by the original act of 1972, a national reserve was established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of appropriations, exclusive of noncontiguous States adjustment funds, for entitlement periods 1 thru 5. No funds were retained for addition to this reserve in entitlement period 6 or 7. Beginning with entitlement period 8 separate reserve funds were established for each State as required by the 1976 amendments extending the original act. Reserves for each State were thus established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of each State's respective portion of the appropriation, exclusive of noncontiguous States adjustment funds, for entitlement periods 8, 9, and 11. No funds were retained for addition to State reserves in entitlement period 10.

The respective cumulative amounts in national and State reserves are available to the Secretary of the Treasury to satisfy legitimate claims against the trust fund for prior entitlement periods. The amounts retained in the trust fund as obligated adjustment reserves will be reduced whenever the Secretary determines that such amounts are adequate and exceed the foreseeable liabilities against the trust fund. The reduction will be made by paying the excess amount to recipients as part of a regular or special distribution.

FINANCIAL HIGHLIGHTS

[In millions of dollars]

	Inception through Sept. 30, 1980 (EP 1-11)	Oct. 1, 1979 through Sept. 30, 1980 (EP-11)
For the period:		
Cash available	55,792	8,651
Payments to recipients	53,955	6,829
Returned to Treasury	15	
At period end:		
Cash distributable (net payables)	1,710	1,710
Obligated adjustment reserves:		
National reserve	22	22
State reserves (total)	90	90
Cash balance	1,822	1,822
Other:		
Appropriations received	55,792	6,855
Reserve funds utilized:		
Reserve funds allocatad for period adjustments	34	2
Special distribution of excess funds from national reserve	50	

STATE AND LOCAL FISCAL ASSISTANCE TRUST FUND, STATEMENT OF FINANCIAL POSITION, SEPT. 30, 1980

Assets:	
Cash balance with U.S. Treasury	$1,821,889,203
Accounts receivable	40,269
Total	1,821,929,472
Liabilities and fund balance:	
Accounts payable:	
Current	1,705,511,455
Deferred (note 1)	4,658,469
Total liabilities	1,710,169,924
General fund: Obligated adjustment reserves (note 6)	111,759,548
Noncontiguous States adjustment fund: Funds not allocable—to be returned to General fund of the Treasury	
Total fund balance	111,759,548
Total	1,821,929,472

The accompanying notes which follow "Analysis of Changes in Fund Balance," are an integral part of this statement.

STATE AND LOCAL FISCAL ASSISTANCE TRUST FUND

	Inception through Sept. 30, 1980 (EP 1-11)	Oct. 1, 1979 through Sept. 30, 1980 (EP-11)
SUMMARY OF CHANGES IN CASH BALANCE		
Cash balance beginning of period		$1,795,800,120
Transferred into trust fund	$55,792,257,000	6,854,924,000
Total cash available	55,792,257,000	8,650,724,120
Less:		
Entitlements paid	53,954,958,208	6,828,834,676
Returned to general fund of the Treasury: Noncontiguous States adjustments not allocable (note 2)	15,409,589	241
Total reductions	53,970,367,797	6,828,834,917
Cash balance end of period	1,821,889,203	1,821,889,203
Analysis of ending cash balance:		
Reserves for obligation adjustment (note 6)	111,759,548	111,759,548
Noncontiguous States adjustments funds		
Available for distribution (note 3)	1,710,129,655	1,710,129,655
Cash balance end of period	1,821,889,203	1,821,889,203
SUMMARY OF CHANGES IN FUND BALANCE		
Fund balance beginning of period		79,543,660
Transferred into trust fund	55,792,257,000	6,854,924,000
Total funds available	55,792,257,000	6,934,467,660
Less:		
Allocations made to recipients (note 4)	55,665,087,863	6,822,707,871
Returned to general fund of the Treasury: Noncontiguous States adjustment funds not allocable (note 2)	15,409,589	241
Total reductions	55,680,497,452	6,822,708,112
Fund balance end of period	111,759,548	111,759,548
Analysis of ending fund balance:		
Reserves for obligation adjustments (note 6)	111,759,548	111,759,548
Noncontiguous States adjustment funds: Funds not allocable—to be returned to Treasury		
Fund balance end of period	111,759,548	111,759,548
ANALYSIS OF CHANGES IN FUND BALANCE		
General funds:		
Balance beginning of period		79,543,660
Transferred into trust fund	55,750,000,000	6,850,000,000
Total available	55,750,000,000	6,929,543,660
Allocations made to recipients (note 4)	55,638,240,452	6,817,784,112
Funds not required—returned to general fund of the Treasury		
Total reductions	55,638,240,452	6,817,748,112
Obligated adjustment reserve (note 6):		
Balance beginning of period		79,543,606
Addition to reserve	196,125,076	34,250,015
Adjustments (note 5)	(50,000,007)	
Reserve funds allocated for prior period adjustments	(34,365,521)	(2,034,127)
Balance in reserve end of period	111,759,543	111,759,548
Balance end of period	111,759,548	111,759,548
Noncontiguous States adjustment funds:		
Balance beginning of period		
Transferred into trust fund	42,257,000	4,924,000
Total available	42,257,000	4,924,000
Allocations made to recipients	26,847,411	4,923,759
Funds not allocable—returned to general fund of the Treasury (note 2)	15,409,589	241
Total reductions	42,257,000	4,924,000
Balance end of period		
Fund balance end of period	111,759,548	111,759,548

The accompanying notes which follow are an integral part of this statement.

Note 1. Accounts payable—deferred.—Amounts shown as deferred were previously eligible for payment but such payments were delayed due to court order or failure of recipients to file required assurances, certifications and reports or for other status reasons such as those resulting from jurisdictional changes (annexations, disincorporations, etc.) in process.

Note 2. Funds not allocable.—$241 in noncontiguous States adjustment fund appropriations received for EP 11 were determined "not allocable" and returned to the general fund of the Treasury in December 1979. These funds exceeded the maximum amounts permitted for use by the 1976 amendments (Public Law 94-488) to the original act.

Note 3. Available for distribution.—The total available for distribution excludes any moneys due the fund but not as yet returned by recipients. It corresponds to the net amount payable (total payables less receivables) to recipients. The amount available Sept. 30, 1980, includes approximately $1.7 billion disbursed to recipients Oct. 7, 1980, as the last quarterly payment of entitlement period 11.

Note 4. Allocations made to recipients.—Includes funds allocated from the obligated reserve for entitlement period adjustments and special distributions of excess reserve funds.

Note 5. Reserve adjustments.—A computer distribution of $50,000,007 in national reserve funds, accumulated during entitlement periods 1 through 7, was made in September 1977 for payment to recipients with their regular Oct. 7, 1977, payment (last payment of entitlement period 8). These funds were determined to be in excess of identified or foreseeable liabilities against the trust fund relating to entitlement periods 1 thorugh 7. The distribution approved by the Secretary was made to recipients on the basis of their entitlement period 8 computer allocations and applied as an adjustment to entitlement period 7 computer allocations.

Note 6. Obligated adjustment reserves:

National reserve.—All funds in this account were obtained from appropriations authorized by the State and Local Fiscal Assistance Act of 1972 (Public Law 92-512). Reserves were established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of the appropriations, exclusive of noncontiguous States adjustment funds, for entitlement periods 1 through 5, plus variances totaling $43 due to rounding in the final allocation process for entitlement periods 1 through 7. No funds were retained for addition to the reserve from entitlement period 6 or 7 appropriations since the reserve fund balance at the beginning of those periods was determined to be sufficient. A total of $102,687,543 was set aside in this reserve during entitlement periods 1 through 7. All allocations from the reserve for entitlement period adjustments through entitlement period 7 (Dec. 31, 1976) were made from this national reserve account. The balance in this account on Dec. 31, 1976, was $73,200,089.

Amounts remaining in the national reserve account on January 1, 1977, are available to satisfy legitimate claims (allocation adjustment increases) against the trust fund relating to entitlement periods 1 through 7 and, when determined excess to identified or anticipated needs, are available for general distribution to recipient governments. During entitlement periods 8 through 11, a total of $877,313 of the January 1, 1977, balance was used for adjustments to entitlement periods 1 through 7. In addition, $50,000,007 determined excess (note 5), was allocated for distribution to recipient governments in entitlement period 8, leaving a balance of $22 322,769 in the national reserve on September 30, 1980.

State reserves.—The eighth period in the revenue sharing program was the first period authorized by the 1976 amendments (Public Law 94-488) to the State and Local Fiscal Assistance Act of 1972 (Public Law 92-512). These amendments required the establishment of separate reserve funds for each State beginning with entitlement period 8 (January 1, 1977). State reserves were therefore established and amounts added thereto on the basis of one-half of 1 percent (0.5 percent) of each State's respective portion of the total appropriation, exclusive of the noncontiguous States adjustment funds, for entitlement periods 8, 9, and 11, plus variances totaling $33 due to rounding in the allocation process for periods 8 through 11. On this basis a total of $93,437,533 was set aside in respective State reserve accounts for those entitlement periods. $4,000,754 of the amount set aside was subsequently used for adjustment of allocations during entitlement periods 8 through 11 leaving a balance of $89,436,779 in State reserves on September 30, 1980.

Reserve Composition and Activity

The following table shows the composition of total reserves and respective national and summarized State reserve account activity:

	National reserve	Summarized State reserves	Total reserves
Entitlement period 11:			
Balance beginning of period	$22, 335, 384	$57, 208, 276	$79, 543, 660
Additions		34, 250, 015	34, 250, 015
Adjustments			
Reserve funds allocated for period adjustments	(12, 615)	(2, 021, 512)	(2, 034, 127)
Balance end of period	22, 322, 769	89, 436, 779	111, 759, 548
Program inception through Sept. 30, 1980 (end EP 11):			
Balance beginning of period			
Additions	102, 687, 543	93, 437, 533	196, 125, 076
Adjustments (note 5)	(50, 000, 007)		(50, 000, 007)
Reserve funds allocated for period adjustments	(30, 364, 767)	(4, 000, 754)	(34, 365, 521)
Balance end of period	22, 322, 769	89, 436, 779	111, 759, 548

FUND STATUS

Antirecession Fiscal Assistance Fund

The Public Works Employment Act of 1976 (Title II, Public Law 94-369) established an antirecession fiscal assistance fund in the U.S. Department of the Treasury to provide financial aid to State and local governments during sustained periods of high unemployment. The fund could be used only for payments to State and local governments as provided in the act. The 1977 amendments (Title VI, Public Law 95-30) to the act of 1976 (effective July 1, 1977) extended the antirecession program through September 30, 1978, and authorized payments to territorial governments. The original act appropriated $1.25 billion to the fund for five calendar quarters beginning July 1, 1976. Additional appropriations of $632,500,000 and $1,400,000,000 were received in May 1977 and October 1977 respectively. These funds were available for use as required under the amended program. Total appropriations received funded the program for nine calendar quarters (July 1, 1976, through September 30, 1978).

The original act of 1976 and the 1977 amendments to that act provide for the use of a formula based upon national unemployment rate data to determine the amount of the appropriation available for distribution each quarter. Quarterly amounts authorized and available for distribution in the nine periods covered by the original and amended act are as follows:

	Start—	End—	Amount
Quarter period:			
1	July 1976	September 1976	$312,500,000
2	October 1976	December 1976	250,000,000
3	January 1977	March 1977	312 500,000
4	April 1977	June 1977	312,500,000
5	July 1977	September 1977	520,150,000
6	October 1977	December 1977	429,250,000
7	January 1978	March 1978	398,950,000
8	April 1978	June 1978	308,050,000
9	July 1978	September 1978	186,850,000

The first disbursements under the original act were made in November 1976 and included payments for quarters 1 and 2 (July 1–December 31, 1976).

To eliminate the prospect of recurring computations of allocations of all recipient governments when adjustments to individual allocations are required and to insure the integrity of the fund, the Office of Revenue Sharing has established adjustment reserves. Beginning with period 5 reserves were maintained in three separate accounts. One account each for States, local governments, and territories. Amounts were retained for addition to reserves on the basis of one-half of 1 percent (0.5 percent) of the funds available for distribution each quarter for periods 1 through 6 and 8 (territorial reserves only). No funds were retained for addition to reserves in periods 7 and 9. Allocations waived by governments were also deposited in reserve accounts upon their return to the fund.

Cumulative balances in respective reserve accounts are available to the Secretary of the Treasury to satisfy legitimate claims against the fund. The amount retained in the fund as adjustment reserves are reduced whenever the Secretary determines that such amounts are in excess of identified or foreseeable liabilities against the fund. The reductions are made by paying the excess amount to recipients as part of a regular or special distribution.

The statements following show: The cumulative results of financial operations from inception through September 30, 1980; results of operations for the 1-year period (October 1, 1979 through September 30, 1980); and the status of the fund as of September 30, 1980. There were no disbursements made from the fund during the fiscal year ended September 30, 1980.

ANTIRECESSION FISCAL ASSISTANCE FUND

FINANCIAL HIGHLIGHTS

	Inception through Sept. 30, 1980	Oct. 1, 1979 through Sept. 30, 1980
For the period:		
Cash available	$3,282,500,000	$2,223,566
Payments to recipient (returns)	3,028,525,762	(672)
Funds not allocable, returned to general fund of Treasury	251,750,672	672
At period end:		
Cash distributable (net payables)	2,223,566	2,223,566
Adjustment reserves:		
State reserve		
Local reserve		
Territorial reserve		
Cash balance	2,223,566	2,223,566
Other:		
Reserve funds utilized:		
Allocated for period adjustments	1,201,353	
Special distributions from reserves	11,745,184	2,223,566

ANTIRECESSION FISCAL ASSISTANCE FUND

STATEMENT OF FINANCIAL POSITION, SEPT. 30, 1980

	Amount
Assets:	
Cash balance with U.S. Treasury	$2, 223, 566
Accounts receivable	
Total	2, 223, 566
Liabilities and fund balance:	
Accounts payable:	
Current	
Deferred (note 1)	2, 223, 566
Adjustment reserves (note 4)	
Total	2, 223, 566

Note: The accompanying notes which follow "Summary of Changes in Fund Balance," are an integral part of this statement.

ANTIRECESSION FISCAL ASSISTANCE FUND

	Inception through Sept. 20, 1980	Oct. 1, 1979 through Sept. 30, 1980
SUMMARY OF CHANGES IN CASH BALANCE		
Cash balance beginning of period		$2, 223, 566
Transferred into fund	$3, 282, 500, 000	
Total cash available	3, 282, 500, 000	2, 223, 566
Less:		
Payments to recipients (returns)	3, 028, 525, 762	(672)
Funds not allocable—returned to the general fund of the Treasury	211, 705, 672	672
Total reductions	3, 280, 276, 434	
Cash balance end of period	2, 223, 566	2, 223, 566
Analysis of ending cash balance:		
Adjustment reserves (note 4)		
Available for distribution (note 2)	2, 223, 566	2, 223, 566
Cash balance end of period	2, 223, 566	2, 223, 566
SUMMARY OF CHANGES IN FUND BALANCE		
Fund balance beginning of period		
Transferred into trust fund	3, 282, 500, 000	
Total funds available	3, 282, 500, 000	
Less:		
Net allocations made to recipients (note 3)	3, 030, 749, 328	(672)
Funds not allocable—returned to the general fund of the Treasury	251, 750, 672	672
Total reductions	3, 282, 500, 000	
Fund balance end of period		

The accompanying notes which follow "Summary of Changes in Fund Balance," are an integral part of this statement.

Note 1. Accounts payable—deferred.—Amounts shown as deferred payables resulted from a special computer allocation distribution of adjustment reserve funds ($695,664, $1,491,401, and $36,501 from State, local, and territorial reserves, respectively) to recipient governments in the last quarter of fiscal year 1979 (note 4). Disbursement of these funds is being delayed to have funds available to pay any necessary adjustments should such arise as the result of pending litigation such as "Board of Supervisors of Henrico County, Va. v. W. Michael Blumenthal, et al." This case concerns the treatment of county highway funds with respect to the derivation of adjusted taxes in the revenue sharing allocation formula. The district court decided the case adversely to ORS. The Fourth Circuit Court of Appeals reversed the district court's decision on July 10, 1980. A petition for rehearing was denied on Sept. 16, 1980. Accordingly, the ORS expects to be able to make a final distribution of the above-mentioned funds to eligible recipients in the near future. The ORS will delay the redistribution only until the time period for further appeal to the Supreme Court has expired, or until the Supreme Court has ruled on any such appeal.

Note 2. Available for distribution.—The total available for distribution excludes any moneys due the fund but not as yet returned by recipients. It corresponds to the net amount payable (total payables less receivables) to recipeints.

Note 3. Allocations made to recipients.—Includes amounts allocated from adjustment reserves.

Note 4. Adjustment reserves.—A special computer distribution (allocation) of $694,664, $1, 491,401, and $36,501 from State, local, and territorial reserves respectively, was made in September 1979 (see note 1). The distribution was made to eligible recipients on the basis of the governments' fractional share of the total quarter 9 allocation, including subsequent adjustments thereto, of record as of the distribution date. Governments that were not eligible to receive an allocation for quarter 9, or who voluntarily or constructively waived their entitlement for that period, did not share in the distribution.

ITEM 14. ACTION

JANUARY 15, 1981.

DEAR MR. CHAIRMAN: I am pleased to submit current information on ACTION's programs for "Developments in Aging," the annual report of the Senate Special Committee on Aging.

The dedicated service by approximately 291,0000 volunteers age 60 or over in ACTION programs is significant evidence that older persons can be a part of the solution rather than a part of the problem. Of the 269,000 RSVP volunteers serving in March 1980, 39.8 percent were age 60–69, 45.3 were between 70–79, 10. 6 percent were between age 80–84, and 4.3 percent were age 85 and over. These volunteers contributed approximately 54 million hours of service worth an estimated $167 million based on a minimum wage rate of $3.10 an hour. In SCP and FGP, where volunteers serve 20 hours each week, approximately 21,000 seniors were serving in March 1980 and 13 percent of them were age 80 and over. Last year's activities in connection with the 15th anniversary of the foster grandparent program revealed there were 98 foster grandparents who had been serving with their local projects since their inception. All of these older American volunteer programs are authorized under title II of the Domestic Service Act of 1973, as amended.

The volunteers in service to America (VISTA) program under title I continues to tap the wealth of knowledge and skills of older Americans. Approximately 15 percent of the VISTA volunteers are themselves age 55 or older. Approximately 22 percent of all VISTA projects are specifically designed to assist in the solution of poverty and poverty-related problems of older people.

Other programs under title I include a community energy project in one city where over 200 households of elderly residents benefited from the energy conservation efforts, and 20 other communities have joined in similar efforts. The 25 State Offices of Voluntary Citizen Participation, many funded by ACTION are presently involved in efforts to encourage the growth of older American volunteer programs in their States.

The enclosed statements summarize ACTION's major older American volunteer activities during the past year.

Sincerely,

SAM BROWN, *Director*.

Enclosures.

OLDER AMERICAN VOLUNTEER PROGRAMS

The older American volunteer programs provide an opportunity for persons over 60 to apply their time and energy to unmet community and individual needs. The programs have the dual yield of improving the well being of both those volunteers who are serving and those who are served. There are no educational or experience requirements for enrollment; participation in the foster grandparent and senior companion programs is limited to persons whose income is not more than 125 percent of the poverty line established by the Economic Opportunity Act of 1964, as amended annually. They receive a stipend of $40 for a 20-hour week. The stipend is not considered income for tax purposes nor does it affect eligibility for other Federal or State programs. Retired senior volunteer program volunteers receive no stipend.

All volunteers serve under the sponsorship of local organizations. Categorical grants are awarded by ACTION to private, nonprofit organizations and public agencies which recruit, train, place, and support volunteers. Day-to-day supervision is provided by volunteer stations which are public or private agencies and organizations such as proprietary health care organizations, hospitals, day care centers, units of local governments, and community action programs. ACTION field staff provides technical assistance to sponsors and training for project staff. Funding is shared between the sponsor and ACTION.

ACTION is committed to the principle that the satisfaction of each volunteer is a direct result of her or his involvement in activities which will improve the lives of others and enrich their own. OAVP seeks to:

(1) Encourage the recognition of older persons as a solution to problems rather than as a problem.

(2) Influence OAVP projects to develop program activities which include advocacy, self-reliance, and mobilization of local resources to meet local needs.

(3) Coordinate OAVP program activities with other ACTION programs including VISTA and Peace Corps.

(4) Encourage volunteer assignments in RSVP and FGP which increase cross-generational contacts.

(5) Encourage increased State and/or local funding of OAVP and OAVP-type projects.

The OAVP program concept has been greatly expanded by the use of State and local moneys to create non-ACTION OAVP-type projects or to supplement existing ACTION projects. More than 30 States and local governments are providing approximately $15 million for this purpose. These moneys are in addition to the required local matching funds provided by all project sponsors. Since most State and local projects wish to be identified with one of the respective OAVP program titles, they have entered into written memoranda of understanding with ACTION. These memoranda allow the local projects to use the generic Federal program name and make the volunteers serving in these projects eligible for the income disregard provision of ACTION legislation with respect to foster grandparent and senior companion programs. Project staff participate in ACTION training activities, receive program assistance materials and utilize the technical expertise of ACTION staff.

OAVP has made a special effort to encourage members of minority groups to participate as volunteers and sponsors in all three programs. More than 17 percent of RSVP volunteers, 40 percent of foster grandparents and 37 percent of senior companions were minorities in fiscal year 1980. Continued emphasis has been placed on recruiting males, elderly persons, and the handicapped.

Volunteer totals and funding for fiscal year 1980 was:	*Millions*
RSVP (269,000 volunteers)	$26.2
FGP (17,370 volunteers)	46.9
SCP (3,820 volunteers)	10.2
Total OAVP (290,000 volunteers)	83.3

Improved cooperation with other agencies that deliver social services is a major OAVP objective. A summary of existing interagency agreements includes:

Agency	*Purpose*
Administration on Aging (AoA), title III.	To have at least one ACTION OAVP project in each AoA service area.
(Title VII is merged under title III)	To assign senior volunteers to assist in achieving the purpose of the title III nutrition program.
	To provide opportunities for seniors to serve children as well as other seniors in public schools.
State agencies on aging agreements with each ACTON State program office.	To promote use of ACTION full- and part-time volunteers to serve in State AoA programs.
ED, Office of Education, right to read (RTR).	To assign senior volunteers to assist with literacy programs sponsored by RTR.
Department of Commerce, National Fire Prevention and Control Administration.	To engage senior volunteers in a public education program to reduce fire loss in their communities.
ED, Bureau of Education for the Handicapped.	To utilize senior volunteers in public awareness and advocacy activities to promote community responsiveness to the requirement of the act.
DOT, Urban Mass Transportation with Administration on Aging (title III at HHS).	To assist in identification of transportation services for lonely and isolated elderly persons.
HUD, Public Housing Administration	To develop a mutual benefit program where senior volunteers can be recruited from public housing where they live to help satisfy the basic human needs of other public housing residents of all ages.

Agency	*Purpose*
HHS, Administration for Children, Youth and Families (ACYF).	To coordinate more use of foster grandparents and RSVP volunteers with ACYF programs for children who are abused and neglected, or in danger of being separated from families, or are in need of foster care and adoption, or who are classified as status offenders, runaway youth, and teenagers facing special problems.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

The retired senior volunteer program was established to provide a variety of opportunities for persons aged 60 and over to participate more fully in the life of their community through significant volunteer service. Through RSVP, over a quarter million older Americans are making significant contributions toward solving some of the pressing problems of their communities. In turn, the program enables the elderly to find the dignity and usefulness they seek.

RSVP was originally authorized in 1969 and funded in 1971. In July, 1971, it was transferred to ACTION.

As an inherently local program, each RSVP project is locally planned, operated and administered, and supported on a cost sharing basis. The non-Federal support of the budget may not be less than 10 percent during the first year. Grantees are expected to increase the local share of the project costs by 10 percent each year and to assume a minimum of 30 percent financial responsibility at the beginning of third year and each year thereafter. Exceptions to this requirement may be granted by ACTION in individual cases of demonstrated need.

A person, 60 years of age or over, is eligible to join the program. There are no income, education or experience requirements to becoming an RSVP volunteer. Orientation, in-service instruction and recognition are provided for the volunteer. Volunteers serve without compensation, but transportation assistance is provided between their homes and volunteer assignments when needed. Accident, personal liability, and when appropriate, excess auto liability insurance are also provided.

Too often older citizens have been regarded as a problem. The retired senior volunteer program sees them as a resource capable of improving community life. They serve in hospitals, schools, courts, crisis centers and other similar agencies, assisting clients of all ages. They are involved in projects dealing with health care delivery, energy conservation, operation of food co-ops, and fixed income counseling. Numerous examples illustrate the value of the contributions of RSVP volunteers to their communities.

Aware of the need for low cost food in their area, a group of RSVP volunteers in Cazenovia, N.Y., established and are now operating a successful food co-op serving low income and home-bound elderly in their community. These volunteers are involved in every aspect of management of the cooperative. They purchase, package and deliver food items to their clients.

In Detroit, Mich., about 100 volunteers have been trained to conduct house to house energy audits and to educate citizens on how to conserve energy.

In Brockton, Mass., a number of volunteers are assigned to a local probate court to help protect the rights of children from broken homes and provide the emotional support they desperately need. One volunteer speaking of the reward he gets from providing this service states, "There's plenty of reward. Its the feeling that you're doing something worthwhile . . . that you give the love to the children."

Over the years, several experimental efforts involving existing projects have been implemented to ensure the development of more innovative service opportunities for volunteers now serving in the program.

In 1978, 113 test components were given technical assistance and some additional funding to develop volunteer services in the areas of: advocacy, deinstitutionalization, criminal justice, housing/food and energy conservation. A year after it was initiated, close to 2,000 volunteers became involved in this nationwide effort.

In 1979, 10 RSVP projects were given additional funds and training to establish components in Fixed Income Consumer Counseling (FICC) that would recruit and train volunteers to assist persons on fixed incomes in areas such as: health and nutrition, crime and victimization, banking, and financing, rebate programs, legal aid and other services.

With funding support and technical assistance provided by a cooperating private agency, 22 RSVP projects started work in 1980 to establish test components with volunteers who will provide community support services to hardcore unemployable youths between the ages of 16 and 21. In early 1981, RSVP will embark on a cooperative effort with the senior companion program to test the feasibility of involving RSVP volunteers in the provision of long term care services to homebound elderly people.

Since 1971, the retired senior volunteer program has experienced considerable growth. In 1972, with a budget of $15 million, there were 84 RSVP projects and 1,816 senior volunteers. By the end of fiscal year 1980, with a budget of $26.2 million, there were 707 federally funded projects and approximately 269,000 senior volunteers participating nationwide. There are RSVP projects currently operating in all 50 States, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. Many States have appropriated over $2 million in support of program activities.

In 1980, RSVP volunteers contributed approximately 54 million hours of service worth an estimated $167 million based on a minimum wage rate of $3.10 an hour.

Older Americans serving as RSVP volunteers, have, through their achievements, earned the respect and support of their own communities, the aging network and professional gerontologists. They have not only proved to be formidable advocates of their own interests, but remain independent and productive contributors of services to their communities rather than just recipients.

FOSTER GRANDPARENT PROGRAM (FGP)

The foster grandparent program (FGP) was originally developed as a cooperative effort between the Office of Economic Opportunity and the Department of Health, Education, and Welfare. It was given a legislative base in 1969 and transferred to the Administration on Aging in HEW. In July 1971, the program was transferred to ACTION.

The FGP enables low-income persons aged 60 or over to remain active in their community through person-to-person service to children with special or exceptional needs in health, education, welfare, and related settings. The foster grandparents derive a renewed sense of dignity and self-worth from their special service roles. In addition to a stipend, they receive additional tangible benefits in the form of transportation to and from their volunteer station, a noon meal on the days (usually 5 days per week) they serve, accident and liability insurance, and an annual physical examination.

Children are assigned foster grandparents on the basis of their potential for improvement in personal or social adjustment, skill development and for deinstitutionalization. In the latter case, foster grandparents will follow deinstitutionalized children needing continuing attention to their own homes when possible and approved. Initial assignments of foster grandparents are also made in cases where they can have the greatest impact in the delay or prevention of institutionalization of children living in a home environment.

Foster grandparents give attention and affection to the children to whom they are assigned. Ideally, the volunteers spend 2 hours with each of two children on a daily basis. Some group settings are not permissive of a strict one-on-one assignment basis. In these cases, foster grandparents may serve several children as long as the setting is conducive to the establishment of person-to-person relationships among the volunteers and the children they serve. The program provides social, psychological, and educational benefits to children with developmental disabilities and related special needs. The foster grandparents simultaneously benefit from alleviation of some of the consequences of poverty and loneliness. Their psychological outlook and physical health are improved. The mutually benefiting relationship also has a notably positive effect on the children's development and the outlook of their families. The program provides a degree of protection of human rights of both "grandparent" and "grandchild," ensuring that each group is dealt with fairly and humanely.

Foster grandparents are provided orientation prior to assignment to individual children. Subsequently they are provided monthly in-service training. They function as stipend volunteers and are not in the regular work force. Their activities are limited to those which would not supplant the hiring of or result in the displacement of employed workers, or impair existing contracts for service. Foster grandparents may not provide physical therapy, babysitting service, housecleaning service, or other services normally performed by volunteer station staff to the children they serve. Foster grandparents are expected to accept supervision of volunteer station and project staff. Appropriate volunteer grievance and appeal procedures are the responsibility of the individual project sponsors.

Project staff are employees of the project sponsor; they are not employees of the Federal Government. ACTION requires concurrence in the selection of project directors.

The project director, on behalf of the sponsor, recruits, trains, and exercises general supervision over the volunteers. This person also develops memoranda of understanding with volunteer stations where volunteers are to be placed. He/she also ensures that foster grandparents are assigned to children with demonstrated special needs.

Project sponsors, in accepting ACTION grants to operate foster grandparents projects, agree to abide by agency regulations and policies. ACTION, in turn, provides training and technical assistance to sponsors and project staff, and promotes cooperation and coordination with other Federal, State, and local entities concerned with the needs of low-income elderly and children with special needs, including transportation needs.

The foster grandparent addresses the most pressing basic human needs, both in seeking the poorest of the poor to serve as foster grandparents, and in the selection of individual children the volunteers serve.

During the entirety of fiscal year 1980, the program operated under authority of a continuing resolution at a level of $46.9 million. At year's end there were 17,370 funded foster grandparents serving approximately 51,000 children. There are 208 (federally funded) projects with at least one project in each State; Puerto Rico, the Virgin Islands, and the District of Columbia. Additionally, more than 30 States have now appropriated varying sums to expand foster grandparent opportunities and services. Michigan presently leads the way in this regard with 8 nonfederally funded projects in operation, providing approximately 360 additional low-income elderly residents the opportunity to serve in and benefit from the program.

The stipend was increased effective November 3, 1979 from $1.60 per hour to $2 per hour.

SENIOR COMPANION PROGRAM (SCP)

The senior companion program offers volunteer opportunities to adults, age 60 and older, who have annual incomes which fall below the poverty guideline. The senior companions (volunteers) provide personal assistance and companionship to primarily older adults in an effort to support them in achieving their highest level of independent living.

The senior companion program has grown from 18 pilot projects and 1,000 senior companions in fiscal year 1974 to 62 projects and approximately 3,820 senior companions as of December 1980. The operating budget in fiscal year 1980 was $10.2 million.

The senior companion program provides a visible demonstration that older persons can perform a critical role in contributing to the solution of problems that affect them. SCP fosters independence and enhances the self-esteem of the senior companions by engaging them in activities which improve the lives of individuals and communities.

An SCP volunteer in Michigan had been hospitalized seven times over a period of 20 years in a State institution for the mentally ill. The volunteer had experienced periods of severe depression and isolation prior to becoming a senior companion. Since joining the program in 1975, the volunteer has not been hospitalized and has become increasingly independent and satisfied with life.

SCP assists in meeting the long-term care needs of moderately and generally impaired adults, focusing on older adults whose physical, mental and emotional impairments put them at risk of inappropriate or unnecessary institutionalization. Senior companions are placed at or through volunteer stations, which are direct health care providers, social service agencies, and Federal and State long-term care networks.

In Indianapolis, a senior companion noticed her client seemed disoriented, and she watched her closely. She eventually discovered the client was taking 23 different prescription drugs—from several doctors, of course; one not knowing she was going to another—she made a list of the drugs, with the doctor's names and the pharmacy. With the help of the project director, she made the doctors and the pharmacists aware of the situation and the client was put under the care of one doctor.

Approximately 80 percent of the senior companions are assigned to assist older persons to remain in their own places of residence.

The senior companions also assist clients in patient-release programs in acute care hospitals, mental health, and other long-term care facilities to make the transition and adjustment to living in less restrictive settings.

In all placements, the senior companions serve as advocates by linking clients to appropriate services and assuring that they receive benefits to which they are entitled.

Senior companions receive a stipend for their service. They are also provided or reimbursed for transportation and meals for days of service, orientation or training. Volunteers are covered by accident and liability insurance and receive annual physical examinations. Senior companions are also provided an orientation and regularly scheduled in-service instruction.

During 1980, eight test projects were initiated. The new concepts incorporated into the project design included: (1) the integration of senior companions into a plan of care developed by community organizations with the capacity to coordinate the health and social needs of clients served; (2) enrichment of volunteer training; (3) increasing the role of the senior companion, clients, and other older low-income persons in the advisory council; (4) strengthening of volunteer station roles and responsibilities; and (5) expansion of senior companion program services to special at-risk populations, the mentally impaired, the aging, those with substance abuse problems, and patients from acute care hospitals.

OFFICE OF VOLUNTARY CITIZEN PARTICIPATION

The Office of Voluntary Citizen Participation (OVCP), in its effort to develop ties between Federal and private sector voluntary efforts, has supported many projects for and involving older Americans. It has accomplished this through awarding of grants to local projects, emphasizing the role of older citizens in its special projects, informing the State Offices of Voluntary Citizen Participation about older American programs, and working with the older American volunteer programs to inform the S/OVCP's of their accomplishments and potential.

The minigrant program provides small grants, not to exceed $5,000 each, for local communities or $10,000 for statewide projects, to private voluntary organizations for support of ongoing volunteer efforts, and for use as seed money to establish volunteer programs. Of the 105 minigrants awarded in fiscal year 1980, seven were for projects for older Americans or to organizations of senior citizens. For example, the National Indian Council on Aging in Albuquerque, N. Mex., developed a project to recruit older Americans as volunteers to work with their Indian peers in developing such life skills as budgeting money. Fifty volunteers are participating in this project.

The support service assistance program provides grants averaging $35,000 for technical assistance, training and materials development to private voluntary organizations to support volunteer efforts or programs. Of the 14 grants awarded in fiscal year 1980, one grant was awarded for an older American project: the Older Women's League Educational Fund. A preconference to the 1981 White House Conference on Aging was held in Des Moines, Iowa. The monies provided scholarships for 16 volunteers to attend the conference where proposals were developed and contacts made among 400 conferees in preparation for the 1981 White House Conference on Aging. Besides ACTION, the Administration on Aging, the Department of Labor/Women's Bureau and the International Paper Corporation funded this project.

The community energy project (CEP) offers technical assistance and information to communities across the U.S. to initiate short-term energy conservation campaigns involving citizens helping themselves and their neighbors to apply low cost/no cost techniques to save energy. There are presently 20 communities receiving intensive technical assistance (site visits) besides the numerous communities who have heard of the success of the program and called or written for assistance. The project has emphasized the plight of low income and the elderly during fuel shortages and the means to incorporate these two groups into the program. For example, due to the active participation of social service agencies in Fitchburg, Mass., including the Council on Aging, the project was able to contact elderly residents who normally may have not received the information. Caseworkers of one agency took application forms for weatherization materials to shut-ins who were visited on a weekly basis. Many of these individuals received materials free of charge.

The project concentrated its crew assistance effort on the elderly. Crews of high school students, college students, and other citizens volunteered to weatherstrip doors, caulk windows and insulate hot water heaters in homes of residents who were unable to do their own work. Over 200 households of elderly residents received this service. With hypothermia threatening older people more than ever during the energy crisis, this weatherization effort in Fitchburg was crucial, both to protect the health of the elderly and to help them save money. Since the winter of 1979, 20 other communities have joined in similar community energy conservation efforts. All projects have emphasized services to the elderly.

In order to present the 25 State Offices of Voluntary Citizen Participation (S/OVCP's) with ideas on how they can encourage the growth of the older American volunteer program in their States, a packet was designed in conjunction with the older American volunteer program staff which includes information on replication of models and how to identify potential State funding sources. This has been sent to all offices. These offices are in an ideal situation to support the growth of the older American programs. The S/OVCP's provide daily contact, coordination and cooperation with the leadership of private voluntary organizations and the public voluntary action efforts in the State. They are integral parts of the State government and have established relations with departments of aging and State legislatures.

VOLUNTEERS IN SERVICE TO AMERICA (VISTA)

Since the creation of VISTA in 1964, VISTA volunteers have, in a myriad of individual situations, amplified the opportunities offered by government programs so that they work as originally intended and enable low-income people to increase their capacity to deal with poverty problems. VISTA's have, for example, helped poor people revitalize decaying urban neighborhoods, focused attention of medically underserved areas, helped low-income groups to organize and develop consumer and farmers' cooperatives, and advocated for the rights of disabled persons. Continuously throughout its history, VISTA volunteers have also worked to assure older Americans the emotional, physical, and financial security they deserve.

ACTION legislation requires that VISTA encourage "fullest participation of older persons and older person membership groups as volunteers and participant agencies. . . ."

An October, 1980 survey revealed that over one-quarter of the total 4,375 VISTA volunteers are serving people 60 years of age and over. Fifteen percent of VISTA volunteers are themselves 55 years or older including 113 who are over 70. They are assigned to over 20 community based organizations around the country, often working in their own communities.

VISTA's are helping to coordinate senior companionship and recreation programs at local community centers as well as working with meals-on-wheels and the Federal food stamp program to guarantee adequate food and nutritional education to seniors who are homebound. They have helped low-income seniors receive FHA grants for indoor plumbing, weatherization, and home rehabilitation, and have worked to set up food and health cooperatives and rural transportation systems to serve the elderly.

Typical is the Colorado Congress of Senior Organizations, a joint VISTA–RSVP project, whose volunteers have organized a rural transportation system serving the elderly in every county in that State.

Another example is the Energy Extension Services in Michigan (EES). Through their effort, 13 VISTA's, working with the area agencies on aging and with

RSVP volunteers, have coordinated energy audits and weatherization efforts on a statewide basis.

In conjunction with an RSVP program in upstate New York, a VISTA volunteer works with handicapped elderly people who still want to work but are isolated due to their handicap. The volunteer with the support of local agencies and businesses, has established a variety of volunteer positions for their elderly clients.

In addition, the volunteers organized a committee of interested elderly people to study the problem of architectural barriers. They published a list of agencies, businesses, restaurants, and other services that were accessible to handicapped persons.

More specific examples of VISTA serving older Americans follows:

Citizen Advocates for Better Care, Leominster, Mass.—Under a national VISTA grant to the National Citizens Coalition for Nursing Home Reform, four VISTA volunteers are working on behalf of nursing home residents in the Leominster-Fitchburg area. Two of the VISTA's make daily visits to area nursing homes and serve as local ombudsmen working to resolve any complaints the residents have. The two VISTA's also assist in coordinating the visits of the citizens who volunteer their time to visit specific homes on a regular basis.

A third volunteer, a retired businessman, has assisted the group with publicity and fund raising. The higher profile of the group in the community has boosted its membership and increased the number of citizens who volunteer their time to the group. This volunteer also regularly visits the area nursing homes to deal specifically with the special problems of male residents. A fourth volunteer provides the group with research on nursing home issues. Largely through the efforts of this volunteer, CABC has received a major grant from the area agency on aging and was asked to be a part of the State ombudsman network to assist groups in other areas of the State with training on nursing home issues.

Grey Law, Los Angeles, Calif.—Along with providing legal services for the elderly, Grey Law is involved in projects relating to senior citizens problems of a nonlegal nature. In Los Angeles, a particularly outstanding problem facing seniors and one which VISTA is confronting, is housing. VISTA's have been instrumental in establishing a housing coalition which has sought to include the vast number of Los Angeles housing and tenants rights organizations into one unified and effective body. In addition to getting the coalition off the ground, VISTA's are performing an essential communication function, contacting the various groups in the Los Angeles area in attempt to provide information about the new organization and encouraging widespread participation in the coalition.

In addition to these and other programming efforts, VISTA has linked with ACTION's older American volunteer programs in implementing two White House on Aging miniconferences.

UNIVERSITY YEAR FOR ACTION AND OLDER AMERICANS

University Year for ACTION (UYA) volunteers work in programs which directly or indirectly benefit senior citizens in a variety of localities. UYA volunteer activity which is primarily focused on seniors includes somewhat isolated activity such as the volunteer working on feeding and nutrition problems of the elderly in Tchula, Miss., to longer programs such as a senior citizens folkcraft cooperative located elsewhere in the rural South.

In addition, there is a large-scale UYA program with the University of Georgia's Gerontology Center in Athens. There, approximately 20 volunteers work with low-income elderly on such issues and concerns as consumer education, therapeutic services, counseling and advocacy for the handicapped.

ITEM 15. CIVIL AERONAUTICS BOARD

JANUARY 12, 1981.

DEAR MR. CHAIRMAN: You asked for information on our initiatives and programs that had either a direct or indirect impact on the elderly during 1980. This information is to be included in the annual report, "Developments in Aging."

Last year we reported that airlines had been allowed to offer special discounts to the elderly on an unrestricted reserved-seat basis but that none had chosen to do so. In 1980, at least two airlines, Air Florida and Wright Air Lines, offered unrestricted discount fares for senior citizens. About 10 other carriers continue to offer standby fares for the elderly. Under these fares, reservations can be made only 1 day in advance.

On April 10, 1980, the Board approved a final rule to prohibit discrimination against air travelers on the basis of age. This rule is required by the Age Discrimination Act of 1975, which exempts discounts for the elderly from the general prohibition against age discrimination. The rule incorporates that exception. This act requires that the Board's age discrimination rule be submitted to the Department of Health, Education, and Welfare (now Health and Human Services) for review. Our rule was submitted to HHS last April and we are awaiting their approval.

In addition to prohibiting age discrimination in air transportation, the rule would require airlines to complete a written self-evaluation of compliance with the Age Discrimination Act, and when requested, provide the Board and the public with information, including the self-evaluations, to determine whether there has been a violation of the act's provision. The rule would also establish procedures for filing complaints alleging age discrimination by an airline. The rule would permit continued discounts for the elderly.

We believe that Board policy, combined with the major changes of the Airline Deregulation Act of 1978 and the International Air Transportation Competition Act of 1979, has created opportunities for new services and low fares. In recent months several new carriers have announced their intention to initiate low fare air service. These actions, as well as the increasingly competitive airline industry that reduced regulation has fostered, will benefit all air travelers, including elderly persons who may have previously found air transportation to be too costly.

I hope you find this information helpful.

Sincerely,

MARVIN S. COHEN, *Chairman*.

ITEM 16. COMMISSION ON CIVIL RIGHTS

DECEMBER 17, 1980.

DEAR MR. CHAIRMAN: The U.S. Commission on Civil Rights is pleased to respond to your request for a statement concerning our fiscal year 1980 activities affecting the interests of older persons.

If we can be of any further help on this or any other matter, please let me know.

Sincerely,

LOUIS NUNEZ, *Staff Director*.

Enclosure.

REPORT OF MAJOR ACTIONS OF THE U.S. COMMISSION ON CIVIL RIGHTS— FISCAL YEAR 1980

The U.S. Commission on Civil Rights is a temporary, bipartisan agency within the executive branch of the Federal Government, established by the Congress in 1957 and directed among other things, to study and collect information about legal developments relating to discrimination because of race, color, religion, sex, age, handicap, or national origin and to appraise Federal laws and policies with respect to discrimination or the denial of equal protection of the laws, and submit reports, findings, and recommendations to the President and the Congress.

Before October 1978, the Commission's jurisdiction over "age" and "age discrimination" matters was limited to a special short-term mandate of the Age Discrimination Act of 1975 (Public Law 94–135) that the Commission study and report on the nature, scope, and extent of age discrimination in federally assisted programs. The Civil Rights Commission Act of 1978 (Public Law 95–444), however, expanded the Commission's general authority to include matters related to age discrimination.

In addition, the 1978 Amendments to the Older Americans Act (Public Law 95–478) directed the Commission to undertake a study of race and ethnic discrimination in federally assisted programs and activities for older persons, examining in particular employment, the award of contracts, and the delivery

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of services. No funds have been appropriated by Congress to finance the costs of the study; however, because the directive was prompted in part by the findings of the Commission's 1977 age discrimination study, and because the Commission believed the results of such a study would be useful to the forthcoming White House Conference on Aging, the Commission decided to allocate a portion of its existing budget to initiate an effort that conformed essentially to the intent of Congress.

The plans for the study focus on an examination of programs authorized under title III of the Older Americans Act at the Federal, State, and local levels. The plans also provide for a review of employment at the Federal, State and local levels with respect to minorities and policies and practices related to the delivery of services and the award of grants and contracts as they relate to minorities. Research is being carried out in Washington, D.C., and in selected cities throughout the country. The Commission anticipates issuing its report early in fiscal year 1982.

In May 1980, the Chairman testified on behalf of the Commission before the Senate Special Committee on Aging with regard to "Aging and Mental Health: Overcoming Barriers to Service." The Commission endorsed the provisions of S. 1177, the Mental Health Systems Act, which included special provisions for providing mental health services to older persons. This support was consistent with the Commission's findings in the report of its age discrimination study that older persons were discriminated against because of their age in the community mental health centers program. The Commission subsequently wrote to the Senate Labor and Human Resources Committee urging retention of the special provisions in the bill ultimately to be considered by the full Senate.

In April 1980, the Commission convened a national consultation on "Civil Rights Issues in Physical Health Care Delivery." Specialists from the public and private sectors presented and responded to papers on health care financing and service delivery as they relate to civil rights concerns. Considerable attention was paid to the special problems faced by older persons in obtaining needed health services and in meeting increasing costs that are not satisfied by medicaid or medicare.

The Commission made extensive comments on regulations proposed by the Department of Health and Human Services to implement the 1978 Amendments to the Older Americans Act.

The Commission continued its monitoring and oversight of the implementation of the Age Discrimination Act of 1975, as amended. The Commission wrote to the heads of all Federal agencies subject to the act, urging prompt publication of proposed agency-specific rules as required under the act. The Commission is also monitoring enforcement of the Age Discrimination in Employment Act of 1967, as amended, which is administered by the Equal Employment Opportunity Commission pursuant to the President's Reorganization Plan No. 1 of 1978.

In its research projects and investigations, the Commission continues to take steps to include, where feasible, concerns related to the Commission's age jurisdiction. The Commission has also established ongoing liaison with specialists in aging from both the private and public sectors. The Commission has also expanded its library collection to include works related to "age" and "aging."

ITEM 17. COMMUNITY SERVICES ADMINISTRATION

FEBRUARY 4, 1981.

DEAR MR. CHAIRMAN: The Community Services Administration is pleased to respond to the committee's letter of October 30, 1980, requesting that CSA submit a report on the Agency's activities and programs for the low-income senior adults.

Our report is for fiscal year 1980, as was requested, and includes information on the senior opportunities and services (SOS) program, as well as all of CSA's programs that provided services and assistance in urban and rural areas of our country, where otherwise the services are either inadequate or nonexistent.

The changed format includes narrative program descriptions that detail in some depth and length the catalytic and generative power of SOS grants. Included also, are descriptions of SOS funded research and demonstration grants; description of other CSA programs; activities of CSA's headquarters and regional staffs involvement in community or local forums, State conferences and miniconferences preparatory to the planned White House Conference on Aging (WHCoA) to be convened in Washington, D.C., November 30 to December 4, 1981.

CSA jointly funded with AoA the WHCoA miniconference on energy, convened by the American Association of Retired Persons; the WHCoA six regional miniconferences on the rural elderly, jointly funded by nine agencies and convened by Green Thumb, Inc. CSA singly funded two regional WHCoA low-income elderly conferences, convened by the National Community Action Agency Executive Director's Association (NCAAEDA).

Thank you for the opportunity you have provided CSA to submit information for part 2 of the committee's annual report, "Developments in Aging: 1980."

Sincerely,

WILLIAM W. ALLISON, *Acting Director.*

Enclosure.

SERVICES PROVIDED TO THE ELDERLY POOR DURING FISCAL YEAR 1979 THROUGH PROGRAMS FUNDED BY THE COMMUNITY SERVICES ADMINISTRATION

LEGISLATIVE MANDATE

The Economic Opportunity Act of 1964, as amended, charges the Community Services Administration with the following responsibilities to aid the low income poor:

(1) To identify the needs of poor persons over 60 years old.

(2) To meet identified needs in one or more of the following areas: (a) development and provision of new employment and volunteer services; (b) effective referral to existing health, welfare, employment, housing, legal, consumer, transportation, education, and recreational and other services; (c) stimulation and creation of additional services and programs to remedy gaps and deficiencies in presently existing services and programs; (d) modification of existing procedures, eligibility requirements and program structures to facilitate the greater use of, and participation in, public services by the older poor; (e) development of all season recreation and service centers controlled by older persons themselves, and other activities and services needed to meet the requirements of the elderly poor or to assure them greater self sufficiency.

(3) To make maximum use of the services of other Federal agencies, particularly the Administration on Aging of the Department of Health and Human Services.

(4) To seek sponsorship of programs funded under titles III and V of the Older Americans Act of 1965 as amended.

(5) To develop and carry out pilot projects which aid elderly persons to achieve greater self sufficiency.

(6) To serve the elderly poor in all other components of the Community Services Administration programs.

(7) To plan for the participation of the poor in programs funded under the Economic Opportunity Act; to continuously review programs to insure that the needs of the elderly poor are taken into consideration; to maintain interagency liaison with the objective of a coordinated national approach to the elderly poor, and to determine the need for new programs and recommend legislation to Congress.

DEMOGRAPHIC TRENDS

The number and percentage of persons over 60 since the turn of the century, paralleling improvement in life expectancy and reductions in the birth rate: In 1900, 1 person in 25 was over 60 years old. In 1978, slightly more than 1 person in 10 in a national population of 220 million was over 60 years old. By 2030, the Census Bureau projects that almost 1 person in 6 will be over age 60. The number of elderly people who are poor or near poor has been reduced in the last decade, based on 1978 census data. In 1978, there were 4.8 million older persons in poverty and an additional 3 million older persons with incomes less than 125 percent over poverty thresholds.

Because of the gap in life expectancy between men and women, a high proportion of the elderly poor are females living alone; 40.6 percent of women over age 75 lived alone. The proportion of the elderly poor that is extremely old (age 85 or older) is rising. In 1975, 37.4 percent of the elderly were age 75 or older compared to 29 percent in 1900 and 33.7 percent in 1960.

Economic and Social Trends Affecting the Elderly Poor

There are a number of trends, both positive and negative that have recently affected the quality of life for the elderly poor. Some of the *positive trends* have been:

—Extension of mandatory retirement to age 70. Elderly persons seeking paid employment to supplement retirement income or wishing to continue in their jobs are protected by antidiscrimination laws.

—Increased Federal regulation of private pensions. Enactment of ERISA greatly increased accountability of private sector employers for adequately funding benefits, created mandatory vesting rights for employees and increased portability of pensions.

—Improvements in medical care are increasing life expectancy, thereby the number of citizens who enjoy good health to older ages is increasing.

—Increased tendency to index the level of Federal transfer payments to increases in the cost of living has slowed the erosionary effect of inflation on benefits.

—Laws regarding public accommodation for the physically handicapped have increased access of the elderly to public transportation and public buildings.

—Discounts for senior citizens for transportation, prescription drugs, cultural events, personal services and entertainment are a growing trend.

—Increased provision by Congress of transfer programs and social services programs designed to serve the elderly poor.

—Emphasis on the problems of the elderly by the President. Former President Carter has called for a decennial White House Conference on Aging in 1981.

Some of the *negative trends* have been the acceleration of:

—Increase cost of health care. The cost of physicians' services, hospital care, nursing home care, and day care facilities is increasing. The deficit between medicare benefits, insurance, and the cost of medical care is increasing.

—Increased cost of energy for heating, cooling and cooking. The elderly have been disproportionately affected because many live alone or with a spouse in older, poorly insulated homes, much too large for one or two persons. The aged are more vulnerable to the effects of excessive heat and cold than other adults.

—Increased property taxes. Many of the elderly are forced to sell their homes to pay delinquent taxes. These homes are frequently the owner's only substantial financial asset.

—Rental costs, where there are no rental cost ceilings, are forcing the low income elderly to move to poorer housing accommodations.

—Food costs are increasing relative to other costs. In 1980, increases in the cost of food accounted for slightly less than half of the double digit increase in the cost of living index.

—Failure of private pensions to keep pace with inflation because benefits are paid at a fixed rate, not indexed to living costs.

—Rising fear of physical assault, theft, con games and living in unsafe neighborhoods. In 1975, at least one third of the older population had at some time experienced criminal victimization.

—Fewer opportunities for the elderly to live with children or younger relatives. Currently, the average U.S. family moves every three years, frequently to a different area. Decline of extended families increases the cost of living for the elderly, increases social isolation, and decreases the family support needed for independent living.

—Decline in financial support from children. Increased living costs have created circumstances where two incomes are necessary to support a nuclear family.

—Increases in rental costs are forcing the elderly poor to cut back on food and medical care and/or to move to inadequate housing.

—High rates of conversion of rentals to condominiums are resulting in the elderly poor people being uprooted from long established living patterns. Frequently those affected are unable to find adequate housing they can afford.

—Decline in the number of public transportation routes, particularly in rural areas is affecting the ability of the elderly to get to markets and needed services.

—Increased costs are preventing the elderly from buying the clothing and household furnishings they need for warmth. The cost of shoes has doubled in the last two years. The elderly poor are unable to afford enough clothing to enable them to layer several garments for protection against the cold.

COMMUNITY SERVICES ADMINISTRATION PROGRAMS

CSA funds programs assisting low income older persons through section 221, local initiative funding of community action agencies, section 222, special programs and assistance and section 232, research and demonstration programs. CSA grantees, particularly community action agencies and national grantees funded to provide backup assistance in specialized areas, act as a network that links together and focuses on the needs of the elderly poor, and garners assistance from Federal, State, and local government and voluntary sources.

The major CSA programs providing assistance to the elderly poor are local initiative programs, senior opportunities and services programs, community food and nutrition programs.

Generally, programs designed to meet the needs of the elderly poor in local communities, whether by advocacy, better integration of services at the State level and at the point of delivery, or by direct services, are funded and administered by regional office. Programs which advocate for the interests of the elderly as they are affected by national policies, most programs which test new approaches to serving the elderly poor, and programs which provide specialized support to regionally funded programs are funded and monitored by the CSA national office.

SENIOR OPPORTUNITIES AND SERVICES PROGRAMS

Senior opportunities and services programs was authorized by the 1967 amendments to the Economic Opportunity Act. The program was intended to provide assistance for meeting those problems of the elderly poor that could not be met by CSA programs serving all age groups. In 1979, CSA revised its priorities and funding policies for SOS programs to assist the increasing numbers of vulnerable and frail, elderly poor persons to remain in their homes and avoid institutionalization; to assist the elderly poor to organize and advocate for their own interests; to strengthen the capability of grantees of the Community Services Administration in planning and programing; and to help the elderly avoid criminal victimization. The policy areas adopted were: outreach and follow-through, access and advocacy, innovative programing and integrated services, income maintenance and employment, elderly victimization, independent living, nutrition, transportation, and age discrimination. The new CSA policies are equally enforceable on all grants made by headquarters and regional offices. (See attachment A for the SOS policy statement for 1980.) In 1979, CSA also changed its program reporting to yield information on unduplicated numbers of beneficiaries in each policy area. The new reporting system, the Interim Data Highlight, began in the last quarter of 1979. The 1980 annual report reflects additional programmatic information collected under the new system. Currently available data on beneficiaries by our two major SOS policy areas is summarized in attachment B.

Funding of Headquarters and Regional grantees during fiscal year 1980 is summarized in attachment C.

Independent Living

The greatest emphasis in SOS programs nationwide has been to provide a variety of types of assistance designed to prevent unnecessary institutionalization of older people, and to assist them to continue to lead full lives.

Senior opportunities and services programs and community action agencies' activities help elderly poor people apply for property tax rebates, appeal rises in assessments, repair homes, qualify for weatherization programs, qualify for assistance in paying utility bills, lower fuel bills by practicing simple, but effective energy conservation tactics and receiving food, clothing, shelter and medical care in emergencies. Community action agencies and SOS projects find housing accommodations, stimulate construction of housing units for elderly poor people, and help them obtain homemaker services, visiting nurse services, and home delivered meals. CAA's and SOS projects sponsor immunization and health screening clinics, health education classes for the elderly, and exercise programs. The agencies also operated community centers for low income elderly people where they do craft work, hold social activities, provide congregate meals, organize educational and cultural programs, plan outings, exchange services and share activities with children and teenagers. CAA and SOS volunteers telephone and visit homebound and isolated older people to provide companionship and information. Other SOS national and local priorities and policy statements are summarized in attachment A.

Independent Living—A Local Project

Project Involve, Inc., a delegate agency of the Community Relations-Social Development Commission (CRCSDC), the local community action agency, city and county of Milwaukee is a low-income senior adult program designed to provide neighborhood outreach, information, referral and followthrough and advocacy to bring community organizations together in a coordinated and comprehensive manner to confront and conduct activities for low-income senior adults.

Project Involve, Inc., received $184,000 in fiscal year 1980 from the SOS program funds. This funding generated $763,590 in additional monies from 12 additional Federal, State, county and city sources. Project Involve offers comprehensive services through five senior centers located in areas of high elderly concentration. The program provided 25 different types of services to more than 29,000 low-income seniors to enable them to continue to live independently with self-respect and dignity still intact.

The services provided to them included clothing, home-delivered meals, emergency food, employment, financial assistance, and counseling, food stamp assistance, friendly visitation, homemaker help, housing repair, legal aid, health care, consumer education and shopping assistance, social security and SSI eligibility aid, tax/rent relief assistance, telephone reassurance, emergency transportation, senior companions and outreach, information, referral and followup and other services. These comprehensive services enabled the program to serve 4,362 new unique persons who had not been assisted in prior years.

Innovative Programing and Integrated Services

CAA's have put together and are operating integrated services by combining categorical programs with SOS and local initiative funding, volunteer and fund raising efforts. CAA's are participating increasingly with area agencies on aging (AAA) in developing area plans, and as program operators. A common pattern is for a CAA to operate a congregate meals program funded from AoA, title III, bring people outreached by SOS staff to the meals by means of AoA, a Department of Transportation, or by an SOS funded program. Afterwards a crafts and social session organized by SOS staff, might be provided and held in a center funded by the Administration on Aging, HUD, a city or county. Another common pattern is for elderly shutins outreached by SOS staff to receive home delivered meals, homemaker services, comprehensive health care and other services such as legal counseling provided under an agreement with an area agency on aging (AAA), a city or county council on aging, or a city or county human services office.

A low-income elderly program participant may be living in a house that has been weatherized by a CAA program combining CETA title VI funds for labor costs, Department of Energy funds for materials and CSA funds for energy crisis assistance and administration. The resident may have also participated in a CSA funded energy conservation education program to increase the benefits from the investment in weatherizing the house.

At the national level, CSA's sponsorship of innovative programs focuses on projects designed to stimulate research and training of professionals and paraprofessionals to work with the elderly poor. Regionally funded programs stress innovative methods of integrating services and inventive types of services such as networks to barter services and home produced items.

Innovative Programing and Integrated Services: A City Program

In New York City, the Community Development Agency, New York City's community action agency, received in fiscal year 1980, $445,251 from the Community Services Administration's SOS program funds to develop and maintain 16 core services/information/access centers in 15 neighborhood development areas as immediate response mechanisms to ongoing problems of the low-income senior adults and as bases for the development of new programing and comprehensive, integrated programs for this expanding segment of the city's population.

The SOS program funds generated another $2,649,000 in funding from other sources and enabled the centers and a network of subsites to assist or provide services for 681,232 low-income senior adults.

The three primary areas of service delivery were: nutrition (congregate and home delivered meals); information and referral including information dissemination and case advocacy in areas such as employment, entitlements, housing, etc.; and integrated general services including home care, counseling, social/cultural/recreational programs and group services.

One of the SOS projects, the Nutrition and Social Services Center, located in a United Methodist Church in the upper, westside of the city served its one millionth meal in July 1980. The Nutritional and Social Services Center serves congregate meals each day to an average of 450–500 seniors and its "meals-on-wheels" delivers nearly 100 meals each day to homebound seniors. Part-time staff and volunteers deliver these meals in compartmentalized, sanitized containers by means of small upright, two-wheeler carts that can be loaded with 6 to 8 hot meals and lifted aboard a bus or subway. This center serves a densely populated area of 10 square blocks comprised of old highrise apartment buildings largely occupied by single elderly individuals or couples.

Access and Advocacy

The senior opportunities and services (SOS) programs and community action agencies' activity help low-income older people qualify for food stamps, emergency energy assistance, social security benefits, SSI, veteran's benefits, medicare, homemaker services, visiting nurse services, and pensions. CAA's advocate on behalf of applicants with officials and represent applicants at fair hearings. Statewide federations of low-income senior programs in 11 States have combined with other SOS grantees and CAA's to organize groups and associations of low-income senior citizens and provide training in the legislative process to enable the low-income elderly to advocate effectively for their own interests.

Access and Advocacy: A Statewide Program

The Colorado Congress of Senior Organizations (CCSO), from the time of its initial funding, has had as its major foci the organization of low-income senior adults to advocate for themselves in order to change restrictive local and Colorado State laws and to assist these seniors to gain access to the services and entitlements for which they are eligible.

CCSO initiated and is a participant in a coalition between the Senior Edition, the Senior Lobby and the senior discount programs. Currently, CCSO is statewide federation of 52 organizations of older persons involved in training the elderly to be their own advocates and provide them with the Federal, State, and local entitlement program information. This has been accomplished through the development of a statewide legislative advocacy communication and training network.

In addition, CCSO administers an ombudsman and legal services program through a network of local advocates all around the State. Some of these are volunteers; some are senior aides; some are VISTA volunteers and a few others are paid staff. CCSO is developing linkages with national reform organizations, such as the Citizens Coalition for Nursing Home Reform.

During fiscal year 1980, CCSO targeted for special emphasis the needs of the Native Americans and Hispanics within the State. It sought to involve local groups of these minority and ethnic populations, as well as other seniors, in local forums that were held in nearly every community throughout the State in preparation for the October 1980, Governor's White House Conference on Aging. The CCSO director, the legislative liaison, and the former board chairperson were keynote speakers at the White House Conference on Aging-Colorado State Regional Conferences.

CCSO, the ACTION State office and the Colorado Agency on Aging have four interagency agreements through which they have combined nearly $1 million of grant funds from CSA/SOS, ACTION/VISTA and the Administration on Aging (AoA)/State agency on aging to make a major, concerted and comprehensive effort to assist the low-income senior adults in every area of the State. CCSO is the lead agency and will administer and monitor the grant programs.

Outreach, Information, Referral, and Followthrough

Outreach, information, referral and followthrough are the means used by local SOS programs to locate the elderly poor, to determine who needs which services, and to link the individual to the services provided by the CAA, the area agency on aging (AAA) local government, the voluntary sector and other available resources.

Volunteers and community aides, funded by section 221, local initiative funds, outreach elderly poor people, as well as SOS outreach workers who are funded specifically for this purpose. Providing coverage in rural areas is particularly difficult and expensive on a per contact basis because of the distance involved between each client and the relative lack of service delivery programs.

CSA stresses the importance of followthrough on outreach contacts, by not counting as beneficiaries in 1980, individuals who were contacted and assessed but did not receive any additional assistance. Other outreach methods used included community meetings, newsletters, and the development and distribution of directories of available services.

Outreach, Information, Referral and Followthrough: A Countywide Senior Program

The Division of Senior Programs of Tioga Opportunities Programs, Inc. (CAA) since its origin in 1968 with a $24,258 grant from CSA for a senior opportunities and services (SOS) program has grown from a small outreach (information and referral) service to a comprehensive, coordinated services delivery system for the elderly. The target group has been in the past, and continues to be, the low-income, frail older persons of Tioga County, N.Y. Since 1974, the dollars received from CSA for the senior opportunities and services program has remained at a level of $40,000. However, with ingenuity and creativity this money has generated several hundred thousands of dollars to implement new programs and fulfill many of the needs and concerns older people have living in a rural county, where public transportation does not exist. The total elderly population for the county in 1980 was 6,000 with 36 percent at or below the poverty level.

One of the first and still major needs the SOS program of TOP, Inc. began to address, after receiving the first SOS funding in 1968, was transportation. With the purchase of an eight-passenger station wagon, low-income older persons were transported to medical appointments and grocery shopping. Since that time, with the addition of new funding from the State office for the aging (title III-B) and Department of Transportation (UMTA 16(b) 2), the program now has four 12-passenger vans, one of which is equipped with an automatic wheelchair lift for handicapped persons. The vans are radio equipped and the demand response system is used for maximum efficiency in a rural area.

Persons 60-plus are transported to nutrition sites, doctor and medical appointments, social service agencies, shopping centers, banks and other necessary locations. Persons call the coordinator in their area 24 hours in advance, with the exception of the medical vans where calls are made directly to the office and a schedule for the driver is made. Persons are picked up at their door. A total of 18,680 one-way seat trips were provided in 1980.

In addition to transportation, outreach service was provided, starting in 1969 on a one-to-one basis where referrals were received.

In 1974, the title VII nutrition program was implemented with the county legislature designating Tioga Opportunities Program to administer the program. This nutrition program became a part of the division of senior programs, and four sites were opened in areas of Tioga County where the largest number of low-income elderly were located.

The number of congregate meals served in 1980 was 37,205 and 11,272 meals-on-wheels delivered to the homebound, frail and low-income elderly.

In 1975, the Tioga County Legislature by resolution designated T.O.P., Inc., through its division of senior programs to act on their behalf as the office for the aging to receive title III-B funding. This gave an expansion of services as well as adding the planning function to the division of senior programs. New sources of funding and innovative programs have resulted, as well as the integration of existing services and the tie-in with other social service agencies in the county—further coordinating and filling gaps in service.

The outreach component, which is still funded by CSA's senior opportunities and services program is the link that ties the program together. The outreach aides are the "eyes and ears" for the program and as such are able to obtain and give information and referrals that are vital to meeting the grass roots needs of the elderly poor. Paraprofessionals employed by this program have had a minimum of 3 years training on-the-job including workshops on counseling techniques, college credit courses in psychology and sociology of the aged, summer seminars at local institutes and numerous conferences on aging. Among the many services this component provides are: Assistance in obtaining entitlements and other services, such as medicaid, medicare, food stamps, S.S.I., social security, VA pensions, legal, tax break, fuel programs, rent subsidy, FHA grants, public health nursing services, transportation, meals-on-wheels and companion-chore services. Assistance entails making application for those who are blind/disabled, accompanying them to various services as supporter and advocate and education to participants on eligibility for services.

Outreach aides work directly with hospitals, social workers on discharges, obtaining in-home services, consultation on prescription or over the counter drugs used by participant. Hygiene problems are dealt with when requested, assistance with phone calls is given for those who have visual or audio difficulties. Shopping for groceries, supplies, prescriptions, etc. is done by the outreach workers. Above and beyond the call of duty, they help hanging curtains, gluing furniture, finding homes for pets when requested and dealing with family problems. All these things may not seem important but help to keep the "human" aspect in the services and give peace of mind to the participants.

The outreach staff assist with health fairs, foot clinics, pap smear clinics, glaucoma clinics, sponsored by the division of senior programs. They do outstanding public relations in dealing with town and village officials as advocates for the elderly clientele. In addition, they help to train the student interns from Cornell University in the field work they are so adept in; 885 participants, 90 percent of whom were of limited, low-income were served by this program in 1980. Additionally, 180 participants were served by the two friendly visitors whose job it is to seek out the problems and refer them to the proper sources for solution. Categories of services addressed by the outreach staff and the number in each category follows:

Title IV-A, funding received through the State office for the aging helps to train staff, especially the 9 paraprofessionals to better serve the needs of low-income elderly persons.

Title V is available to the senior program through three sources: Twelve slots are allocated from Green Thumb, Inc.; five slots from Steuben County CAA, under a grant from National Council of Senior Citizens; and seven slots from the New York State Office for the Aging. Those employed are used primarily to supplement staffing of the division in the nutrition program, craft shop, office and friendly visiting services.

Student interns from Cornell and SUNY are assigned to the program during the school year for their practicuum experience. They are involved in learning how to tie in with the community and at the same time they are trained to assist in outreach work. The large print service directory is a product of student work. The program has one or two graduate students per semester for 2 days each, per week. The hours cost out at $10,416 per school year.

CETA personnel and social services work program enrollees are employed in the nutrition program as supplementary food service workers. Their time amounts to 5,630 hours costs out at $17,453 a year.

Recreation is another service that is vital and cost effective in allowing persons to remain independent and alleviate social isolation. Funding for this program is jointly provided through New York State. Recreation for the Elderly via the New York State Office for the Aging and individual municipalities (50 percent from each source). Work is done with groups of 10 or 12 persons in three areas of the county as well as at the nutrition sites where participation ranges from 8 to 15 persons per session. Bead work, macrame, chair caning, ceramics, needlepoint, bargello, oil painting, quilting, plaster craft, knitting projects, tole painting, pen and ink drawing and miscellaneous other craft are made. These skills are also taught to the elderly homebound, including special techniques for the blind and physically handicapped. The craft shop is the sales outlet for these crafts. The shop was opened 3 years ago and at the present time there are 50 low-income senior adults and homebound elderly who have their crafts sold in the shop.

A senior community services employment program employee manages the shop. Contributors therefore receive the full tagged price for their articles, giving a financial subsidy as well as a feeling of usefulness. Outreach workers pick up articles for sale in the shop from the homebound. The end of the year inventory in 1979 was $3,061.85 and sales in 1980 amounted to $4,325.13.

Through a model project funded in 1979 from AoA, Washington, D.C., a companion-chore, minor repair project was implemented that served more than 150 elders 60 years and over. In 1980, funding was through the New York State community services program. The chore program, as it is now called assists elderly persons with household chores, who could not afford to hire help but who also are just over the medicaid guidelines. They are very needy in the sense that they do not qualify for any financial assistance, yet cannot pay the minimum wage for home help and are not physically able to do their housework. This program has been extremely helpful in contributing to independent living by seniors in their own home setting, where they are most comfortable and happy—a viable alternative to costly institutionalization.

A program made available in 1980, to Tioga County's elderly population, "free of charge" is the vial of life program. Cost of vials were contributed to Lourdes Hospital by a large industry and then made accessible to the elderly. In cooperation with the local Sheriff's Department, arrangements were made for laminated photos to be included in the vial for positive identification in case of fire. The vials were placed in the homes of 600 elderly persons so that in an emergency, when technicians respond to a call and find the elderly person unable to talk, the decal on the door signals them to look in the refrigerator under the top shelf where the vial is located and contains all relevant information: name and address, medications, nearest relative, etc. so that treatment can be properly administered. The dollar value of this service cannot be evaluated but it is a lifesaving effort.

Health screenings are done periodically during the year as follows:

Blood pressure readings follow up through their individual physician monthly at four nutrition sites serving a total of 1,412 in 1980. Sixty volunteers contribute time is valued at $4,686.

Pap smears are done twice a year through the family planning clinic serving approximately 80 elderly persons each time. Two volunteers' time is valued at $45.

Foot clinics are also held at 6-month intervals serving 54 seniors each time using a volunteer professional podiatrist and six volunteers whose time is valued at $495.

A yearly health fair is held each May during senior citizens month with screenings in diabetes, hearing, glaucoma, demonstrations in CPR and other information provided through Public Health Nursing Services and the Arthritis Foundation as well as local hospitals.

Another service is sex counseling for the elderly who are beginning a second marriage.

The discount card program made up of 101 local merchants is one method used to alleviate financial stress for elderly living on limited incomes. The program is a four county effort and gives an average of 5–10 percent discount on goods at participating retail stores; 365 businesses in the four-county area participate and 2,422 Tioga County residents have signed up for the picture card at a one time fee of $3.50. Applications are processed for Golden Park Passes available through the New York State Department of Parks and Recreation enabling persons 62 and over to enter any New York State Park free.

In addition to the services discussed above, provided directly by the division of senior programs, other services for the elderly have been generated by advocacy on the part of staff and the elderly themselves. One such program is the two new senior housing complexes located in Owego and Waverly with 32 and 35 units respectively; 84 persons aged 62 and over reside in these units which are subsidized so that renters pay no more than one-quarter of their income for rent and utilities.

The social and physical environment is such that residents feel very much at home. Both 2-bedroom and 1-bedroom apartments are available, but there is a long waiting list at each site.

Rent subsidy is available to 69 low-income elderly in private apartments, homes and mobile units, paying no more than one-quarter of their income for rent and utilities and funded by HUD and DHCR through Tioga Opportunities Program, Inc. Housing Department. Section 8 moderate rehab program also provides rental assistance for low-income tenants, and provides for another 40 units, some of which are occupied by low-income elderly.

A food bank for the poor, including low-income senior adults, is under implementation through T.O.P.'s community food and nutrition program. They have established a tie-in with the Wayne County food bank which is part of a national network to salvage and distribute donated, nonperishable food. The food is trucked to Tioga County by coordination with the local Sheriff's Department where it will be picked up by volunteers from six church related food pantries. The pantries will stock food until requested by a needy household. The nutrition program for the elderly will also be a recipient of the donated food.

The weatherization program under T.O.P., Inc. has winterized 96 elderly homes to make possible independent living in their own homes.

Tying in with other community agencies on behalf of elderly persons and their special needs, are memberships of the director and planner-coordinator on the Public Health Nursing Service utilization and review committee and advisory board, the department of social services advisory board, Riverview Nursing Home consumer board, cancer task force and long-term care committees of New York-Penn Health Planning Agency. A Cornell University professor, Mark Zober, Ph. D., assisted in the evaluation instruments and data collection for the model project independence as well as assisting in a needs survey instrument for the senior citizens division's new area plan for 1981.

As the foregoing information attests, Tioga County Office for the Aging is dedicated to the philosophy of helping low-income senior adults maintain themselves in their own homes as long as possible. It is demonstrated through this agency's experiences in the field of aging that only by the development of a comprehensive network of services, the regular monitoring and evaluation of these services and ongoing program development can the low-income elderly receive the services they require. Paramount in this structure is the outreach component. Even an understaffed, underfunded outreach component can provide more than basic linkages between the elderly and appropriate services providers.

The final accomplishment of this goal of effective service delivery demands dedicated advocacy in the interest of the vulnerable low-income older person, matched by unceasing efforts to forge linkages with other service providers and benefit program administrators. How well and aggressively this has been done by Tioga Opportunities Program, Inc., is illustrated and the two succeeding pages that shows the services and other funds and funding sources generated by $40,000 of SOS program funds a year.

Nutrition and Transportation

Senior opportunities and services programs and community action agencies organize, sponsor, and supplement staffing for communal and home delivered meals provided under title III of the Older Americans Act. CAA's outreach participants, provide transportation to dining centers and provide social, educational, and cultural activities after the meal. CAA's have found ways to prepare meals on-site, economically, from fresh meat and produce. CAA's provide nutrition education to the elderly, and secure assistance for the elderly in preparing meals at home through homemaker programs and voluntary assistance. The agencies also help low-income elderly people qualify for food stamps, as well as assist low-income people to raise their own food and livestock, and hold workshops on food preservation.

Transportation, particularly in rural areas, is a crucial element in bringing the elderly to services, getting services to homebound elderly, and encouraging socialization. Senior opportunities and services programs and community action agencies use agency vehicles interchangeably to provide individual and group transportation to the elderly. CAA's administer grant from the Department of Transportation and other sources to operate scheduled transit and dial-a-ride systems.

CAA's assist elderly poor to use existing transit systems, and to advocate for new routes and favorable fare structures. Transportation is provided for grocery shopping, medical appointments, congregate meals, social activities, and visits to service providers.

Nutrition and Transportation: A Multicounty Rural SOS Program

The senior citizens' program has been operating since 1968, sponsored by Hill Country Community Action, San Saba, Tex. The program, at present, is operating in nine counties; Mason, Llano, San Saba, Mills, Lampasas, Milam, Bell, Hamilton, and Coryell, and received $81,000 in fiscal year 1980 SOS funds.

The program has been able to add a number of permanent facilities for activities in the past few years. At present, there are permanent facilities in Llano (2), Goldthwaite, Hamilton, Gatesville, Copperas Cove, Rockdale (2), Cameron, Killeen, Lampasas and Lometa. Plans have been completed for permanent centers for Hico, San Saba, and Mason. Activities are being held also in Belton, Mullin, Priddy, and Evant. Harvest House in Temple is the base for several programs.

The 21 senior centers have become a base for comprehensive services for the low-income elderly in these nine counties. Below is a brief explanation of each program that is operated in or from the centers that assisted 15,000 elderly poor in fiscal year 1980.

Title III-C—Nutrition.—Funded by the Governor's Committee on Aging, this program provided a hot, nutritious meal to 158,600 persons 60 years of age or over. In addition to the meal, the participants had the opportunity to join in social activities, crafts and educational programs. Many of them volunteered as helpers with all phases of this program funded in the amount of $284,885 in fiscal year 1980.

RSVP.—The retired senior volunteer program is funded by the ACTION agency, with HCCAA as sponsor. This program involved 667 older persons in volunteer work in stations such as senior centers, schools, hospitals, nutrition programs, etc. The purpose is to keep the older person in the mainstream of activities because they have much experience and wisdom to share with other elderly persons. The 189,485 hours of service was valued at $587,404 in fiscal year 1980.

Title III-B.—Funding for social services in the amount of $44,000 was received through a subcontract with the area agency on aging, as part of their funding from the Governor's Committee on Aging. These funds are combined with the basic SOS funding from the Community Services Administration. The combination of funds provides such things as center personnel, supplies, telephones and travel, to operate the centers. Social services, crafts, educational programs, information and referral services, home delivered meals and transportation services are also provided. There are many outlets for the elderly through the center concept.

VISTA.—Volunteers in Service to America, funded by ACTION, provides personnel to work in the centers, nutrition programs, transportation, weatherization and outreach.

Transportation.—Transportation for medical, nutrition and emergency assistance is provided through funds from title III; Department of Human Resources, and rehabilitation programs. Fourteen vans in eight counties provide much needed transportation to the elderly poor. The total transportation funds received in fiscal year 1980 was $160,000 and provided 134,789 one-way rides.

Community food and nutrition.—Funds received from Community Services Administration to provide food vouchers for participants in need of emergency-type assistance. This is a much needed program and requested by many of our local governments.

Energy crisis assistance program (ECAP).—Funded in the amount of $378,000 to provided assistance to the elderly and low income who needed help with payment of excessive fuel and electric bills. This program has been most effective during the winter of 1979–80, and it is expected to be repeated during the winter of 1980–81.

Home weatherization and SSI home repair program.—These programs are funded through the Department of Human Resources. The household must meet the income guidelines, and the funds can be used for weatherization as well as to install safety devices such as handrails, and repair parts of a home considered a health hazard. Neither weatherization nor the SSI home repair includes labor costs. This must be obtained by the family. In many instances, the program has had the use of a Green Thumb crew, and help from the CETA manpower program has been available.

All of these programs described are a part of the coordinated effort to provide comprehensive services to the elderly, using the SOS senior centers as the base or focal point. The total program is accomplished by utilizing a number of funding sources, as well as personnel provided by agencies such as Green Thumb, STEP, VISTA, and CETA manpower. The $81,000 of SOS funds provided the Hill Country was the catalytic funding that generated a total of $2,042,118 of additional funds from other Federal, State, and local resources.

Community Food and Nutrition

Examples of types of CFN programs and program elements with substantial participation of the elderly poor are:

(1) *Chore services.*—A worker comes into the home of the elderly to help with the preparation of meals and to perform other needed household tasks as required.

(2) *Home shopper.*—Elderly people who cannot get out, plan a grocery list with a home shopper who goes to the store to purchase items. The shopper will also plan meals with the elderly who are mobile, prepare shopping lists, and accompany them to the store for purchases. The salary of such "shoppers" is paid by CFN funds.

(3) *Transportation.*—Provided for volunteers to deliver home meals and to assist others to get to Federal nutrition program centers.

(4) *Pantry service.*—Serves as a mobile grocery store for the elderly, and delivers, commodities which the elderly run out of prior to the receipt of monthly checks and these commodities are sold at reduced cost. Food items are supplied by co-op stores and CFN funds pay for the truck driver. The truck routes include homes for the elderly, and apartments and projects where elderly people are congregated.

(5) *Farmer's markets.*—Located in city parking lots have reduced food costs for the urban elderly poor by eliminating the middle businessman.

(6) *Garden and livestock projects.*—CFN projects provide seeds, fertilizers, livestock, feed and information. CETA workers and youth programs participants help with the work that is too physically demanding for elderly participants.

Housing Programs

The CAA's, SOS Projects and other limited purpose agencies funded by CSA indicated in a recent survey that they place housing as a priority need of the elderly poor whom they are serving. With $20 million in local initiative funds and $6 million in 51 research and demonstration programs, grantees in rural areas and approximately 749 CAA's are using section 221, local initiative funds, to help the low income obtain better and more affordable housing.

Elderly persons, who as a group are the most desperately in need of housing assistance, are the greatest beneficiaries of the housing program. This is particularly true with the extensive work that is being done that predominately assist the low income elderly with rural home repair projects. Agency funding enables local organizations to help poor residents of the community qualify for Farmers Home Administration loans and HUD community development block grants. It also undertakes, often with CETA labor, the actual repair of the home. The elderly poor (over 60) especially benefit from this program as they may become eligible for an outright grant if their incomes are too low to qualify for the low interest (1 percent) FmHA home repair loan. There is a greater need for grants to the elderly under the 504 FmHA programs because a major segment of the poor receiving assistance in housing are elderly. CSA programs provide staff support for rural housing development and rehabilitation management of subsidized rental housing and senior citizens housing. During fiscal year 1980, CSA housing office initiated a new national housing program entitled "rural housing initiatives program" that has funded 24 State coalitions to assist the poor, including the elderly poor, to obtain decent housing and related social services, also to improve opportunities for the poor to be involved in mobilizing and channeling additional housing resources to their areas.

Energy Crisis Assistance

The steadily rising costs of the elements essential to life: food, shelter, and energy are recognized as primary to the erosion of the economic stability and advancement of all households, poor and rich alike. In particular, the escalation of energy costs has had all encompassing and dramatically negative, direct and indirect effects on the quality of life. However, in no other strata are the increases felt more keenly than in the community of the elderly poor. Living on fixed and sometimes subsistence level incomes; fighting at minimum, the increasing medical problems brought on by age; often isolated and generally living in the substandard shelter traditionally available and affordable to the poor, the elderly face energy related choices which literally mean life or death.

During the winter of 1979–80, CSA administered the energy crisis assistance program (ECAP). This program was designed to meet the emergency needs of the poor and near poor and gave priority to the elderly through mandating special outreach, accessibility and eligibility considerations. Just short of a million elderly headed households received energy bill paying and other services related to the alleviation of energy crisis conditions. But, in addition to achieving the goal, preliminary ECAP evaluation is indicating that many elderly persons who had never before participated in programs of this nature were identified, involved and provided other vitally needed services.

In the summer of 1980, the heat energy assistance program (HEAP) provided assistance to 161,489 low-income elderly persons affected by the prolonged heat wave. HEAP funds were used to provide transportation to heat relief centers, fans and other cooling devices and in life and health threatening situations, pay utility bills.

In the winter of 1980–81, CSA has funded a $3 million outreach program called project energycare, incorporating the facilities and expertise of various national, State and local aging groups under the coordination of the National called project energycare, incorporating the facilities and expertise of various Council of Senior Citizens. Project energycare is engaged in a massive outreach program geared to ensure low-income elderly exposure and participation in the low-income energy assistance program (LIEAP).

The philosophy of the program is to bring a medicare concept to the involvement of the elderly in energy programs and to further identify and provide other needed services.

The energy crisis intervention program (ECIP) for the 1980–81 program year is operating through the community action agency and SOS networks to provide access to energy related services, leadership in the furtherance of community mobilization, planning and educational activities, replacement or supplement of alternate energy services where appropriate and direct services in the form of goods or services where extreme crises conditions exist and all other sources of aid have been exhausted. ECIP is a crucial element in the total Federal energy program for this year in that it addresses all the energy related needs not addressed by bill payment, and attempts to move the low-income poor and elderly to lesser degrees of energy program reliance.

PILOT, RESEARCH AND DEMONSTRATION PROJECTS—ELDERLY CRIME PREVENTION AND ASSISTANCE PROJECTS

The crime prevention/victim assistance projects of the New York City Community Development Agency (CDA) and the Community Relations-Social Development Commission of Milwaukee County completed in the last quarter of fiscal year 1980 3 years of a highly successful experimental program that was first funded nearly 3 years ago.

The Milwaukee and New York City projects grew out of a conceptual idea generated and developed by program and research personnel of the CR–SDC, the public community action agency of Milwaukee city and county.

The CR–SDC executive director and two of his associate directors are to be commended for the vision, time and energy that went into developing new concepts and techniques of preventing the elderly from being victimized, and if the elderly poor are victimized, then providing them with many types of urgent and critical assistance.

The concept was developed in 1976 and early 1977 as a national elderly crime prevention and assistance program and in 1977 received funding totaling more than $1.6 million for three city projects by CSA and four city projects by the Administration on Aging that totaled more than $1.6 million. Additional funding in the amount of $400,000 was made to the National Council on Senior Citizens by the Law Enforcement Assistance Administration (LEAA) and Housing and Urban Development (HUD) for the coordination, technical assistance and long-term impact evaluation of the projects.

The Milwaukee project has sustained a steady growth during its years of CSA funding, which have totaled $700,000. During this third year, the Milwaukee CR–SDC elderly crime project has already involved more than 2,000 elderly and other interested Milwaukee citizens in influencing changes in public policies to prevent elderly victimization and provide protection to the elderly through block-watch organizations and educational programs to help the elderly avoid being attacked on the streets or in their homes.

The projects during their third year have also assisted more than 500 elderly victims of crime in resolving the many associated problems resulting from their victimization. These included the replacement of personal articles one normally has in his wallet or in her purse as well as the replacement of stolen or destroyed household goods and the provision of temporary housing.

The project also sought to reduce household burglary by installing deadbolt locks on doors, securing ground level windows with a heavy duty, unbreakable plastic cover.

Much has been learned from Milwaukee crime prevention/victim assistance project (CP–VAP) and the New York City project that the CSA can disseminate to other CAA's and cities through the "how to" manuals designed by the projects on planning and startup strategies. Many of the projects' features will serve as models for future projects and will benefit other programs across the country.

The Milwaukee project has been so successful that its component parts have been spun off to other agencies and will no longer require Federal funding. The New York City project through a "no cost time extension" grant action is continuing its project operations through February 1981.

The National Council of Senior Citizens (NCSC) with a small CSA grant of approximately $49,000 has provided training sessions in elderly crime prevention and assistance in Baltimore, Richmond, and Norfolk to the CAA staffs, law enforcement officials and interested community groups to test the validity and utility of the training manuals developed by the Milwaukee and New York City projects, as well as the Criminal Justice and the Elderly (CJE) Department of the National Council of Senior Citizens.

These multiple training sessions in all three cities have been well attended, excellent training experiences for the local CAA staffs, etc. and enthusiastically received by the training participants.

This NCSC funding demonstrated that cities differing in size, cultural makeup, ethnic and racial backgrounds and economies can put into place, at relatively small costs, effective elderly crime prevention and assistance programs.

Comprehensive Home Care for Senior Adults: A City Area Project

A comprehensive care project for homebound senior adults, utilizing neighborhood churches as a primary resource was funded in fiscal year 1979 and began its initial efforts in the first quarter of fiscal year 1980. The project, begun by the West Philadelphia Fund for Human Development, Inc., has through the efforts of three congregations in the Cedar Park-Kingessing section of West Philadelphia and an interfaith coalition of four other congregations in the area, set out on an endeavor to prove that volunteers, particularly those available through local congregations can provide comprehensive care to home-bound low-income senior adults in this poverty area of Philadelphia.

It already has established a case for the premise that a small staff will discover in the network of people connected with local congregations ready-made resources for keeping senior adults out of nursing homes and involved with their peers and society around them.

Lay and professional volunteers have been coordinated in a comprehensive effort to deliver hot meals, do house repairs, negotiate with absentee landlords, design nutritional plans, provide meals and groceries-on-wheels, intervene in health emergencies, maintain a watch on continuing health problems and provide in-home cultural enrichment for home-bound senior adults.

In the first year of its operation, the project has expanded from 5 to 50 senior adults served and from three to seven congregations directly involved in providing assistance to them.

—The expanded project will serve a neighborhood of 15,000 people of whom 15 percent are over 65—2,200 (approximately); (a) 80 percent of whom are near or below the poverty guidelines—1,760; (b) 20 percent need comprehensive, in-home care to avoid institutionalization at some future time—350.

—Hypotheses being tested by the project: (1) Congregations of all faiths constitute an available resource for low-cost, comprehensive in-home care. (2) Volunteers, such as church members, work most effectively in their own neighborhood (parish). (3) Home-bound low-income senior adults are strengthened and their situation improved when the approach is comprehensive and every program is dealt with from every perspective. (4) Senior adults themselves can provide an important part of the comprehensive care delivery system. Involvement in the project gives seniors an opportunity to serve those they know best.

—Components of the project: (1) Legal rights and advocacy—volunteers have been trained to provide services in the areas of taxes, real estate, wills and estates and areas related to the special needs of low-income senior adults. (2) Nutrition and health—daily delivery of food, both meals-on-wheels and groceries-on-wheels. The delivery system also serves as a base for health monitoring and support. Volunteer professionals have concentrated on health education of lay volunteers and of the senior adults. Another emphasis has been on preventative measures and on making use of existing health care facilities. (3) Home and apartment repair and maintenance—a small corps of retired craftsmen has been formed; a revolving loan fund established for senior adults who were unable to secure home improvement loans from banks and grant funds made available to assist in repairs or necessary renovation. This program component has been made possible by a credit union being established and incorporated by the West Philadelphia Fund. (4) Cultural enrichment—volunteers trained in the use of cultural resources meaningful to home-bound senior adults provide them with desired reading materials in large print, recordings for the blind, and readings in braille for the deaf and blind.

A low-wattage UHF radio station license has been secured by the West Philadelphia Fund for Human Development and a broadcast room has been built and all necessary equipment supplied as a gift from a local radio station in Philadelphia. The station will broadcast 2 hours each morning and 2 hours in the early evening. One hour of the morning and one hour of the evening broadcast will be in Vietnamese to serve the nearly 4,000 South Vietnamese who have been located in the West Philadelphia area.

We feel that this project can demonstrate to city communities and to rural areas of our nation that strong, viable and continuing local congregations can form consortia to assist the low income senior adults to remain in their homes, apartments or other housing units and remain independent, retain their individuality, sense of community and self-worth.

The Intergenerational University Service-Learning Centers Project

The purpose of this CSA national demonstration project has been to demonstrate how the human resources of our nation's 3,200 institutions of higher education can be made more available to meet the needs of older persons, particularly those who are poor.

The project has been cooperatively funded since October 1, 1978 by the Community Services Administration, the Robert Wood Johnson Foundation and the seven participating educational institutions. The Robert Wood Johnson Foundation has provided $350,000 and CSA has provided nearly $500,000 to support 2 years of local demonstration activities in seven communities because of their interest in developing systems which increase access to and expand the range of health-related services to older persons. The seven institutions of higher education: Boston University, George Washington University, Hampton Institute, University of Georgia, CUE of Indianapolis, University of Denver and Oregon State University are participating to meet simultaneously the needs of older persons and the needs of the institutions themselves. NCOA is providing leadership to the project because of its expertise in and historical commitment to developing innovative programs and services which improve the quality of life for older persons.

In this project, the objectives of NCOA, the Robert Wood Johnson Foundation and the seven participating institutions complement and reinforce title II, section 222(a)(2), "senior opportunities and services" (SOS) program objectives of the Community Services Administration. Through title II, CSA manifests its commitment to the better focusing of all available resources to enable low-income persons to become self-sufficient.

The primary objective of the SOS program is to "identify and meet the needs of poor persons above the age of 60 in projects which serve or employ older persons as the predominant or exclusive beneficiary group." A basic operating tenet of each local program is to identify and fill gaps in services to older persons, especially those who are poor, vulnerable and isolated.

As a result of CSA participation in the funding of this project, NCOA has taken and will continue to take active steps to assure CSA priorities are reflected in the operation of the local centers. These mutual concerns of both NCOA and CSA are:

(1) *Emphasis on expansion of services to the poor elderly.*—As a result of CSA cooperative funding, NCOA has required of the local participating institutions that at least 40 percent of the elderly served through the project fall within the poverty category. After 6 months of 1980, the campuses report that over 68 percent of the older persons served have been poor. Services to the low-income elderly will continue to be a primary emphasis of the local programs.

(2) *Emphasis on the development of jobs and career training opportunities for low-income students.*—Involving students in need of financial aid means developing programs capable of attracting or generating funds for student support. This has been and will continue to be a major focus of the NCOA technical assistance effort to the participating institutions.

(3) *Emphasis on the ways in which local CAA's can utilize university resources.*—The CAA's in each community have been involved in identifying needs and in the planning and development of the local demonstrations. CAA representatives are on the advisory committees of six communities (there is no CAA in Hampton, Va.). As a regular part of the site visit schedule, NCOA staff meet with regional and local CAA personnel to discuss cooperative ventures. NCOA has developed a model for a followup project which it hopes several CAA's will elect to initiate as a joint venture this year. This pattern of technical assistance and site visits continued during the second year of the project. During the second year, materials are being developed for dissemination to all CAA's about how they can tap into and utilize local college and university resources.

(4) *Focus by university faculty and students on the needs of the elderly poor.*—This project is expanding and improving opportunities for faculty and students to have needed experiences with elderly persons suffering from the effects of poverty. We are already seeing evidence of how these experiences are generating more community interest in the poor, especially the older poor. This may have the long-range effect of facilitating the redirection of some of the intellectual resources of the universities to seek solutions to the causes and social and economic costs of poverty in America.

(5) *Emphasis on the development of in-home, access and followup services for older persons.*—NCOA and the participating institutions are placing special emphasis on the development of service-learning projects which foster independent living of the elderly. Projects which are being planned or are underway include home-help and chore services, outreach, escort, counseling and advocacy, followup and hospital discharge planning. These foci are based on the recognition by NCOA, CSA and the local communities of the dire need to expand and improve services in these areas.

This report provides a summary of the major activities and accomplishments of the intergenerational service-learning project during the 7-month period from January 1, 1980 to August 1, 1980.

Overview of National Staff Activities

NCOA project staff has been proceeding with tasks and activities in accordance with the plan of operation in the most recent CSA highlights memorandum. Staff efforts have primarily concentrated on the following activities:

(1) Continued technical assistance, consultation, and oversight through periodic site visits, telephone, and mail as well as semiannual meetings of local project personnel.

(2) Evaluation and reporting carried out in accordance with the plan and documentation provided to CSA. Some modifications have been made in the evaluation strategy on the basis of recommendations by the Office of Policy, Plans, and Evaluation and the older Americans' office.

(3) Continued assistance to the seven local projects in identifying and soliciting local sources of funds to support various demonstration activities.

(4) Developed outlines of all final project publications. First drafts of selected chapters have been completed for some.

Summary of Local Campus Activities

During the first 7 months of 1980 for each of the seven participating institutions of higher education, over 569 students were involved in providing more than 42,000 hours of services to more than 12,000 older persons. Over 60 percent of the older persons served were poor, significantly exceeding the CSA contractual mandate—at least 40 percent of the persons served be poor.

Each of the seven campuses has developed, identified, and implemented feasible projects which have nationwide implications for colleges and universities. NCOA staff has worked extensively with each of the schools during this time to focus their efforts on the development, expansion, and strengthening of those projects which are most likely to become institutionalized and continued on a long-term basis.

Summary of Public Policy Initiative

A major accomplishment of the intergenerational service learning project during the past 6 months has been the effort to change public policy to enable colleges and universities across the country to replicate or adapt models developed from the demonstration project. Based on the knowledge gained during the first 14 months of the national demonstration, NCOA developed and proposed amendments to title IV–C of the 1980 Higher Education Act. These amendments are designed to provide both an incentive and a means for institutions of higher education to use college work-study students in community service-learning activities on behalf of low-income community residents. For every student who is employed in a qualifying experience, the school will be allowed to retain 2½ times the usual administrative cost allowance. Both legislative language and most of the committee report for these amendments, which are almost certain to be included in the final version of the bill approved by Congress, were written by NCOA project staff.[1] It should be noted that these amendments contribute to the general goals of CSA as well as the SOS program because it encourages the development of student-delivered services for low-income people of all ages. Although it is difficult to accurately predict the impact of a program where participation is voluntary, NCOA staff conservatively projects that by 1983 the amendment will result in a annual involvement of 245,000 students providing over 44,000,000 hours of service for or on behalf of low-income persons.

Plans for the Final Phase of the Demonstration Project

At present, the demonstration project is scheduled to end in July 1981. The Robert Wood Johnson Foundation, which has already provided $350,000 for support of campus activities, recently approved a supplemental grant of $70,000 to enable the campus programs to operate for a second full academic year until June 1981, and CSA provided a supplemental grant of $49,528. These supplemental grants were made in recognition of what the project has been able to accomplish to date and the following potential benefits to the overall demonstration by providing an additional 6 months of program operation:

(1) The findings of the program would be based on local programs which will have operated for 2 full academic years. Excellent progress has been achieved during the first full academic year of the project, but we believe that a second full academic year would yield considerably more exciting projects and results.

(2) National funding of the local programs would be terminated in the springtime and therefore be consistent with the academic budget cycles. This is likely to have a substantial impact on the ability of the local universities to institutionalize the model programs by having an opportunity to incorporate the programs into the normal budgeting process.

(3) NCOA staff could actively participate in the development of regulations relating to the new college work-study amendments and actively encourage utilization of new work-study opportunities at the demonstration sites and other universities nationwide. These efforts could have a critical impact on the extent to which colleges and universities ultimately participate in this new federally supported program. During this time, NCOA could also develop a special techni-

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[1] NOTE: NCOA staff time directly related to this public policy initiative was *not* charged to the CSA-funded account.

cal assistance report aimed at enabling CAA agencies to take full advantage of the new legislation.

(4) NCOA and local universities could do a more complete and extensive dissemination of project findings to encourage project replication throughout the country. During this time, NCOA staff would develop and implement training programs for various conferences and prepare articles for appropriate professional journals. Details of the dissemination efforts will be developed in collaboration with CSA officials.

Health Advocacy for Older Adults: A University Project

The Institute of Gerontology, University of Michigan in Ann Arbor, Mich., was funded to demonstrate how CAA's, AAA's and other area agencies can be brought together to plan, coordinate, and implement health advocacy programs on behalf of the elderly poor. The project covers a four-county area in the State of Michigan: Oakland, Livingston, Jackson, and Washtenau.

The ultimate goal of the project is to improve access to and the quality of health care for the elderly poor residing in the community.

During the first year of operation the Institute of Gerontology researched, developed, and assembled components of the staff/student training program and compiled a training manual. Information includes: physical and psychological aspects of aging, interpersonal skills, advocacy methods, and evaluation instruments. Planned, scheduled, and implemented the staff/student training program. Conducted a health education workshop at the Willow Run Nutrition Site entitled: "Sleep Disorders of Older People and Relaxation Techniques." Researched and developed drafts of five additional pamphlets. Titles are: "Cardiovascular Disease," "The Normal Changes of Age," "Cancer," "Stroke," "You and Your Doctor."

Planned and conducted a peer counselor recruitment program in Jackson, Mich., with the Willow Run/Ypsilanti peer counselors as program presenters and role models. Commenced the peer counselor training in Jackson, developed guide lines for the peer counselor training programs.

The projects' major objectives during the first year were:

(1) Developing model training programs for peer advocates.

(2) Training a cadre of older people in the four-county area to act as peer advocates for the elderly poor in health-related situations.

(3) Developing models of survival education and health education workshops.

(4) Providing survival education to large groups of older people in nutrition and senior centers in a variety of substantive health and consumer issues, in order to make them better health consumers.

LOCAL INITIATIVE PROGRAMS

In fiscal year 1980, the Community Services Administration received $382 million of local initiative (LI) funds. Of this amount, $57 million, more than one-seventh of the total, was spent in the provision of services or assistance to low-income elderly. In fiscal year 1980, the 218 senior opportunities and services (SOS) program allocations totaled $9.2 million. These LI and SOS funds generated more than $450 million from HEW, HUD, USDA, DOL, and State and local sources for low-income elderly citizens. The above local initiative and SOS funds, totaling $66 million allocated by the agency to serve the low-income elderly, do not include other agency funds from the community food and nutrition, energy, rural housing, and the research and demonstration program funds. A considerable part of these funds went to serve the low-income elderly.

THE WHITE HOUSE CONFERENCE ON AGING ACTIVITIES

CSA headquarters and regional offices have adopted several strategies to assure that the special needs of the elderly poor are addressed in the White House Conference on Aging (WHCoA). The scope of our activities has extended to the local, State, regional, subnational, and national level. Whenever possible, CSA at the national, regional, State, and local levels have coalesced activities with other Federal, State, and local agencies whose programs also focus on the elderly. This has not only prevented duplication of effort, it has developed stronger ties where they might not have previously existed. Interagency coordination has included the Department of Health and Human Services; the Administration on Aging, ACTION, and DOE at the national and regional levels, as well as area agencies on aging; RSVP; Foster Grandparents; and Green Thumb at the local level.

For example, a region VII ad hoc advisory committee appointed in July 1980, has guided regional WHCoA activities. This committee, chaired by a CAA executive director, includes representatives from CAA's, region VII CSA, HHS, AoA, and ACTION.

Region VII WHCoA activities which have been completed or which are planned for the near future include:

> *Community forums:* Since September 1980, more than 5,000 citizens of region VII have participated in at least 285 community forums sponsored by community agencies in preparation for the 1981 White House Conference on Aging. At these meetings, the low income have specified needs and recommended strategies to submit to their State White House Conference on Aging.
>
> These forums have adopted many forms. For example: In Iowa, a single meeting attracted 250. In Missouri, a CAA took its meetings to small towns and villages in order to reach residents who might be overlooked in countywide meeting. In Nebraska, a CAA cosponsored forums in unCAPed counties to widen the scope of elderly poor involvement.

Other major events including the elderly include:

> *Iowa Poor Persons Congress:* This was funded by CSA and including elected representatives including elderly from all Iowa CAA's and SOS project. Over 300 persons attended on September 19, 20, and 21, 1980. Resolutions in the areas of health, transportation, housing, and energy, including elderly concerns, were formulated and opted.
>
> *Kansas families and poverty conference:* This was also funded by CSA, and included representatives from all SOS projects and CAA's, most of whom were elderly. Between 200 and 300 attended on June 13, 14, and 15, 1980, and covered such subjects as health and nutrition, upward mobility, economics, and housing.
>
> *Nebraska Silver Haired Unicameral:* On October 14–16, 1980, representatives elected by low-income seniors met in the State legislature (unicameral) and worked out positions and priorities on taxes, transportation, and other matters of interest to the elderly. These will be submitted to the legislature and their progress followed. This was funded by CSA.

NCAAEDA miniconference on poverty and the elderly: Two NCAAEDA sponsored miniconferences on poverty and the elderly were held during the month of January 1981. The first in Kansas City, Kans., January 13–15, 1981. This conference covered regions VI through X. Approximately 220 low income, elderly delegates from 23 States attended. The second conference was in Washington, D.C., January 25–27, 1981, covering regions I–V. Approximately 250 low-income elderly delegates from 23 States attended.

The delegates worked in small groups to refine issues and establish priorities. Each working group presented its recommendations to the full body during a general assembly on the last day.

These two conferences were officially approved by the White House Conference on Aging. The recommendations from the two miniconferences will be distributed to the conference technical committees, to State conference coordinators, to the 2,000 national conference delegates and to the Members of the U.S. Congress.

In conclusion, we believe that the WHCOA activities encouraged by the CSA headquarters office and fully supported by the regional CSA offices and the CAA network represent an outstanding effort—one which is characterized by a high level of interagency coordination and cooperation and, more importantly, by a genuine commitment to advocate the special needs of our elderly poor constituents.

POLICY ISSUES FOR THE ELDERLY POOR

Purpose

The purpose of this project was the development of a series of policy recommendations to be used by CSA in formulating program decisions relevant to the elderly population and for the White House Conference on Aging's technical committees and the 22 Mini-White House Conferences on Aging covened by special interest groups.

The high proportion of elderly citizens in this country who fall into low income categories requires that CSA develop policies addressing the special needs of the elderly be periodically updated. Demographic trends also necessitate further planning for the changing needs of successive aged cohorts.

In an effort to identify the most pressing issues as well as the long-term considerations for policy planning for the elderly the Policy Planning Division of OPPE initiated a three-stage project. Participation of gerontologists active in the field was emphasized to ensure broad, detailed, sophisticated and current analysis of policy-relevant issues.

Work Plan

The project focused on three objectives relevant to policy issues for the elderly poor:

(1) Solicitation, review and presentation of policy papers for the Gerontological Society.

(2) Compilation of a series of policy papers for the 1981 White House Conference on Aging.

(3) Development of a policy statement for CSA addressing the elderly poor.

To accomplish the work plan, CSA solicited papers from gerontologists across the Nation on specific topics under the category of "Policy Issues for the Elderly Poor." Authors were informed that the best of the papers would be presented at a symposium session at the Gerontological Society conference, and that cash honoraria would be awarded. In addition the papers will be included as part of a policy statement on the elderly poor to be sent to the White House Conference on Aging in 1981.

The papers were solicited with the help of the Gerontological Society. Abstracts for papers were requested through a special mailing sent to members of the society announcing a symposium on "Policy Issues for the Poor Elderly" sponsored by CSA at a scientific meeting of the society. Abstracts submitted to the society were reviewed, as per usual society procedure and all of the abstracts were then forwarded to CSA. They were reviewed against the criteria of relevance, policy orientation, comprehensiveness and analytic sophistication. Thirteen of the 96 abstracts were selected for further development as bases for CSA policy planning. The papers will be written by November 1, 1980 and submitted to CSA's older Americans program Office and OPPE.

Objective II

The papers will be compiled and abstracted to be submitted to the 1981 White House Conference on Aging.

Objective III

The papers will subsequently be used as the foundation for a policy statement on the elderly poor for use in program planning within CSA. The papers will be included in a package to be circulated throughout the CSA-CAA network for reference in programing for the 1980's.

In fiscal year 1980, 218 SOS headquarters and regional offices' funded grantees reported serving more than 2 million low-income senior adults. The data displayed in attachment B shows that many of those served received multiple assistance or participated in a number of activities provided by the SOS projects.

In addition to the number of low-income senior adults assisted by the SOS program, as reported elsewhere in this report, more than 1 million other seniors in low-income strata were assisted through the CAA's local initiative fundings and the special assistance programs of community food and nutrition, energy crisis assistance, housing, and research and demonstration.

ATTACHMENT A.—*Older poor persons policy statements*

I. GENERAL CSA OLDER POOR PERSONS POLICIES

CSA's policy on the older poor will focus on the goals of promoting the highest possible level of independent living, preventing or delaying institutionalization, providing supportive services especially for the functionally dependent, increasing the access of the elderly poor to services, and overcoming and eliminating discrimination on the basis of age.

II. SPECIFIC CSA OLDER POOR PERSONS POLICIES

A. Outreach and Followthrough

Policy: CSA will support programs designed to increase the outreach capabilities of CAA's and other community organizations and institutions to reach the older poor.

B. Access and Advocacy

Policy: CSA shall continue to advocate directly and to assist national and local public interest advocacy efforts for the recognition of the needs of the older poor and allocation of resources to meet those needs.

C. Innovative Programing and Integrated Services

Policy: CSA will support programs which coordinate multiservice delivery and simplify and codify application procedures. CSA shall also fund innovative programs which demonstrate an integrated approach in dealing with the total life and environment problems of the older poor.

D. Income Maintenance and Employment

Policy: CSA will continue to support programs to train or retrain the older poor for specific job opportunities that will assist them in supplementing their incomes up to the amount allowed by existing legislation. CSA will advocate for changes in existing legislation which provides for reduced benefits when the elderly increase their earned income. CSA will support vocational rehabilitation programs which do not restrict the full participation of poor older adults.

E. Elderly Victimization

Policy: CSA will support programs, on its own and where appropriate with other federal agencies, which help to prevent the victimization of older poor persons and provide them with appropriate social services if they are victimized by criminals or consumer fraud.

F. Independent Living

(1) Housing.

(2) Energy.

(3) Noninstitutional health care services.

(4) Isolation: *Policy:* CSA will support and encourage programs that will help maintain the independent living style of the older poor, including the following: (1) programs that assist the older poor to retain their current home or to seek improved housing, either owned or rented, in an effort to provide a decent affordable living environment; (2) programs that implement energy conservation to reduce fuel costs for the older poor so that they can maintain independent residences; (3) programs that provide crisis intervention assistance; (4) public policies and health care models which de-emphasize the institutionalization of the elderly and which place emphasis upon community-based home health care assistance; and (5) programs which bring the older poor back into the mainstream of society.

G. Nutrition

Policy: CSA will support programs dealing with both formal and informal nutrition education for the older poor. CSA shall advocate with other federal agencies to redesign programs, legislation, and eligibility requirements to enhance service delivery. At the local level, CSA shall encourage efforts to improve the effectiveness of delivery of food and nutritional services to the older poor.

H. Transportation

Policy: CSA will support programs that will provide the older poor with access to adequate and affordable transportation, particularly in rural areas.

I. Discrimination

Policy: CSA will continue to support in its policies and programs allocation patterns which insure a fair share of resources to all age groups. CSA will support programs and policies which encourage the elimination of age, sex, and race as a factor in determining federally supported services and benefits.

Attachment B.—*Senior Opportunities and Services (SOS) Program National Summary of Program Priorities*

	Number of Services or Assistance Provided [1]
Independent living:	
Housing assistance	913,100
Nutrition: Congregate meals, home-delivered meals, food, pantry service, farmers markets	3,603,300
Home care	819,710
Health care	1,321,350
Elderly day care	5,873,520
Safety and consumer education and counseling	4,872,120
Community or senior centers	12,960
Community or senior center	10,303,200
Access and advocacy:	
Transportation (two-way rides)	2,489,880
New SSI enrollees	344,550
New food stamp enrollees	511,350
New training enrollees	138,570
New jobs provided	471,061

[1] These are duplicated total numbers of low income senior adult services and assistance and are not intended to indicate the number of individuals served or assisted.

ITEM 18. COMPTROLLER GENERAL OF THE UNITED STATES

January 27, 1981.

Dear Mr. Chairman: In response to your committee's October 30, 1980, request for information on our major activities concerning Federal initiatives or programs which affect the aged, we are enclosing a list of reports issued during fiscal year 1980 on reviews of Federal programs that concern the elderly (enclosure I). We have also included a list of audits in process which concern the elderly (enclosure II) and a statement of the General Accounting Office's "in house" activities which related to older persons (enclosure III).

Copies of the issued reports are being provided to your office separately. A summary of the major findings and conclusions for each report is included in a digest bound in the report or in the letter transmitting it.

Sincerely Yours,

Elmer B. Staats,
Comptroller General of the United States.

Enclosures.

Enclosure I.—*General Accounting Office reports issued which concern the elderly*

Title of report	*Date*
Report to Chairman, Subcommittee on Social Security, House Committee on Ways and Means: "Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability" (HRD-79-119).	Oct. 9, 1979.
Letter to the Secretary of Health, Education, and Welfare: "Social Security Should Obtain and Use State Data to Verify Benefits for All its Programs" (HRD-80-4).	Oct. 16, 1979.
Report to the Congress: "Identifying Boarding Homes Housing The Needy, Aged, Blind, and Disabled: A Major Step Toward Resolving A National Problem" (HRD-80-17).	Nov. 19, 1979.
Report to Chairman, Subcommittee on Social Security, House Committee on Ways and Means: "Indirect Costs of the Social Security Administration's Disability Programs are Excessive and Should Be Reduced" (HRD-80-23).	Nov. 19, 1979.
Report to the Congress: "Entering A Nursing Home—Costly Implications For Medicaid and the Elderly" (PAD-80-12).	Nov. 26, 1979.

Title of report	*Date*
Report to the Congress: "Minimum Social Security Benefit: A Windfall That Should Be Eliminated" (HRD–80–29).	Dec. 10, 1979.
Letter to the Secretary of Health, Education, and Welfare: "Changes Needed to Prevent Commuters and Transients From Receiving Supplemental Security Income" (HRD–80–35).	Jan. 4, 1980.
Report to the Chairman, Subcommittee on Health, Committee on Finance, U.S. Senate: "Hospitals in The Same Area Often Pay Widely Different Prices for Comparable Supply Items" (HRD–80–35).	Jan. 21, 1980.
Letter Report to the Chairman and the Ranking Minority Member, Special Committee on Aging, U.S. Senate: "Comparison of Well-Being of Older People in Three Rural and Urban Locations" (HRD–80–41).	Feb. 8, 1980.
Report to the Chairman, Joint Economic Committee, U.S. Congress: "An Actuarial and Economic Analysis of State and Local Government Pension Plans" (PAD–80–1).	Feb. 26, 1980.
Report to the Congress: "U.S. Income Security System Needs Leadership, Policy, and Effective Management" (HRD–80–33).	Feb. 29, 1980.
Report to the Chairman, Committee on Ways and Means, House of Representatives: "Legislation Authorizing States to Reduce Workers' Compensation Benefits Should be Revoked" (HRD–80–31).	Mar. 6, 1980.
Letter to the Chairman, Subcommittee on Human Services, Select Committee on Aging, House of Representatives: "Opportunities are Available for Action to Enhance Older American Voluntarism" (HRD–80–58).	Mar. 7, 1980.
Report to the Congress: "Health Maintenance Organizations Can Help Control Health Care Cost" (PAD–80–17).	May 6, 1980.
Letter to the Chairman, Subcommittee on Oversight, Committee on Ways and Means, House of Representatives: "Evaluation of Health Care Financing Administration's Proposed Home Health Care Reimbursement Limits" (HRD–80–84).	May 8, 1980.
Letter to Senator Bob Packwood: "Evaluation of the Health Care Financing Administration's Proposed Home Health Care Cost Limits" (HRD–80–85).	May 8, 1980.
Report to the Congress: "Slow Progress and Uncertain Energy Savings in Program to Weatherize Low-Income Households."	May 15, 1980.
Report to the Congress: "Need to Prevent Windfall Benefits to Supplemental Security Income Recipients" (HRD–80–44).	May 30, 1980.
Report to the Secretary of Health and Human Services: "States Should Intensify Efforts to Promptly Identify and Recover Medicaid Overpayments and Return the Federal Share" (HRD–80–77).	June 10, 1980.
Letter to Congressman George O'Brien: "Questions About the Cost-Benefit Analyses of the Professional Standards Review Organization Program" (HRD–80–93).	June 12, 1980.
Report to the Congress: "Problems Remain in Reviews of Medicaid Financed Drug Therapy in Nursing Homes" (HRD–80–56).	June 25, 1980.
Letter to the Administrator of HCFA: "Hospital Use of Contract Management Services."	June 30, 1980.
Letter to the Chairman, Subcommittee on District of Columbia, Committee on Appropriations, U.S. Senate: "Financial Audit of the District of Columbia Office on Aging" (GGD–80–70).	July 17, 1980.

Title of report	*Date*
Letter to Senator Bob Packwood: "Oregon's Financial Management of Funds Under the Older Americans Act" (HRD-80-97).	July 17, 1980.
Report to Chairman, Committee on Veterans Affairs, House of Representatives: "VA Improved Pension Program: Some Persons Get More Than They Should and Others Less" (HRD-80-61).	Aug. 6, 1980.
Report to the Congress: "The Lump Sum Death Benefit—Should it be Changed?" (HRD-80-87).	Aug. 8, 1980.
Letters to the Senator Jesse Helms, Congressman Donald Ritter, Congressman Robert H. Michel, Congressman Bill Gradison, Congressman John B. Anderson, Senator Gaylord Nelson, Congresswoman Virginia Smith: "Review of Selected Aspects of Low Income Energy Assistance" (HRD-80-115, 118, 119, 120, 121, 122, 123).	Sept. 15, 1980.
Report to the Congress: "Federal Funding for State Medicaid Fraud Control Units Still Needed" (HRD-81-2).	Oct. 6, 1980.
Letter to the Secretary of Health and Human Services: "Reasonable Change Reductions Under Part B of Medicare" (HRD-81-12).	Oct. 22, 1980.
Report to the Secretary of Health and Human Services: "Continuation of More Model Projects Could Increase the Delivery of Services to the Elderly" (HRD-81-9).	Oct. 23, 1980.
Report to the Congress: "Federal and State Actions Needed to Overcome Problems in Administering the Title XX Program" (HRD-81-8).	Oct. 29, 1980.

ENCLOSURE II.—*General Accounting Office audits in process which concern the elderly*

Questions relating to the effectiveness of the section 8 housing program.[1]

Review of Federal efforts to house handicapped persons.

Survey of Federal efforts to improve transportation to rural areas.[1]

Review of the dine-out features of the food stamp program.[1]

Review of Federal nutrition research planning and coordination.[1]

Review of the Department of Energy's weatherization activities under title IV of the Energy Conservation and Production Act.

Survey of the organizational structure of the Office of Human Development Services.[1]

The need for a separate Consumer Price Index for retirees.

Review of the tax-exempt home health agencies.[1]

The effect of estate provisions on farm and timberland estates.

Review of the effectiveness of State and area agencies on aging.[1]

Establishing a comprehensive, coordinated system of services for older Americans.[1]

Survey of social services provided under the Social Security and Older Americans Acts.

Review of role of sheltered workshops in serving the handicapped.[1]

Followup on certain GAO reports concerning savings potential in vocational rehabilitation programs.

Review of medicare and medicaid controls over physician and supplier program overutilization.

Review of utilization controls for home health services.[1]

Review of the fixed-price contracting experiments in medicare.[1]

Review of revised conditions of participation for skilled nursing facilities and intermediate care facilities.[1]

Review of nursing staff pools and their impact on medicaid-medicare reimbursement.

Review of medicaid cash management.

Survey of reimbursement practices in the end-stage renal disease program.

Review of the Department of Health and Human Services' maximum allowable cost and/or estimated acquisition cost drug pricing programs.

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[1] Being performed at the request of committees or individual Members of Congress.

Review of Professional Standards Review Organization monitoring of delegated hospitals.[1]

Review of medicaid's quality control program.

Survey of medicare's carriers' claims processing system.

Survey of medicare and medicaid utilization controls over hospital ancillary services.

Survey of the interchange of data between the medicare and the worker's compensation programs.

Survey of medicare and medicaid cost allocation.

Review of the revised method of reimbursing durable medical equipment under medicare.[1]

Stopping the short-term worker's advantage could save the social security trust fund billions of dollars.

Supplemental security income resource eligibility criteria and verification procedures.

Uncashed supplemental security income, VA pension and aid to families with dependent children checks.

Implementing GAO's recommendations on the Social Security Administration programs could save billions of dollars.

Review of the administrative procedures of the Labor Department's Office of National Programs.[1]

Survey of specialized services provided by community mental health centers.

Review of need standards used in income transfer programs.[1]

Impact of the social security 1980 increase on recipient other benefits.[1]

ENCLOSURE III.—*General Accounting Office internal activities which involve the elderly*

The equal employment opportunity and merit promotion programs, both covered by GAO orders, provide the basis for our policy regarding employment of the elderly. From the prohibition of discrimination on the basis of age in employment and in the selection for job vacancies, other policies and practices evolve. For instance, because training is important to enhance effectiveness and provide opportunities for advancement, older employees are included in opportunities for training, both in-house and outside the agency.

In keeping with the policy of nondiscrimination, persons over 40 are recruited for available options with the Office. Although employment restrictions limited our level of recruitment for much of the year, 844 persons have been appointed to permanent and temporary positions this year. Of that number, 148 persons (18 percent) were age 40 and older at the time of their appointment.

As of December 31, 1980, 1,870 persons age 40 and older (32.3 percent of our work force) were on the rolls of the General Accounting Office. Although employees in this age group participate widely in all our programs, we especially note that we have three employees age 40 and older in the upward mobility program and one in our cooperative education program. These programs usually draw participants from a younger population.

The employee health maintenance examination, a comprehensive and professional medical examination, is available on a 2-year cycle for all employees age 40 and older. Employees nearing retirement age have available individual preretirement counseling. We conducted two preretirement seminars for 1980 and have additional seminars planned for 1981.

ITEM 19. CONSUMER PRODUCT SAFETY COMMISSION

JANUARY 14, 1981.

DEAR MR. CHAIRMAN: Thank you for providing the Commission with the opportunity to be included in the Special Committee on Aging's annual report, "Developments in Aging."

Improving product safety for older Americans continues to be an important goal of the Consumer Product Safety Commission even though our activities are not directed specifically to programs for the elderly.

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[1] Being performed at the request of committees or individual Members of Congress.

Our submission for the 1980 report is enclosed. Please let me know if you have any questions.

Sincerely,

LINDA B. KISER,
Director of Congressional Relations.

Enclosure.

CONSUMER PRODUCT SAFETY COMMISSION REPORT FOR 1980

The Consumer Product Safety Act (Public Law 92-573) was enacted in 1972 in recognition of the need for Federal regulation to ensure safer consumer products. The act established the Consumer Product Safety Commission and charged it with the mission of reducing the number and severity of consumer product-related injuries, illnesses and deaths. An amendment to the CPSA requires the Commission to "consider and take into account the special needs of the elderly and handicapped to determine the extent to which such persons may be adversely affected by (a consumer product safety) rule."

Our 1980 activities, including injury-data collection, research studies, standards development, and information and education programs, were not directed solely to programs for the benefit of our 20 million older Americans. However, improving product safety for the elderly is an important continuing objective of the Consumer Product Safety Commission. While none of the laws administered by CPSC apply solely to the elderly, the Commission recognized that the elderly are particularly vulnerable to injuries associated with various home structures, including bathtubs, showers, floors, stairs, unvented gas space heaters, and upholstered furniture. Moreover, the Commission has an active interest in developing programs aimed at the elderly.

INJURY DATA COLLECTION

The Commission's primary source of information on product-related injuries is the National Electronic Injury Surveillance System (NEISS). The NEISS is designed to have a statistically selected set of 74 hospital emergency rooms located throughout the country which report to the Commission, on a daily basis, data on product-related injuries treated in those emergency rooms. The Commission estimates that 494,000 persons 65 years of age or older were treated for product-related injuries in hospital emergency rooms in the United States and the U.S. Territories in calendar year 1979. The elderly were hospitalized for these injuries at a much higher proportion (19 percent) than the population as a whole (5 percent). Injuries associated with stairs, steps, floors, or flooring materials were suffered most frequently by the elderly. Other major product categories associated with injuries which particularly affect the elderly are those most commonly found in and around the home, including chairs, beds, doors, ladders, bathtub and shower structures, knives, rugs and carpets.

ACTIVITIES RELATED TO THE ELDERLY

The Commission recognizes that many products used by all segments of the population may present special problems for the elderly. These special problems are examined carefully in our setting procedures.

The Commission has formally recognized the unique needs of the elderly and special population groups in selecting project priorities. The "vulnerability of the population at risk" is one of seven factors which the Commission weighs in determining priority projects.

Unvented gas-fired space heaters and upholstered furniture flammability were two of the Commission's 1980 priority projects. In its review of hazard studies on fires associated with unvented gas space heaters and upholstered furniture, the Commission has noted that elderly Americans are frequently involved in these incidents. This information has been considered in the development of the Commission's final standard for these gas heaters. It was also used in the Commission's consideration of the need for safety requirements for upholstered furniture.

Another 1980 priority was tap water scalding of older consumers. To address this problem, the Commission has successfully worked with voluntary standard organizations to require in their standards that the pre-set temperature for water heaters be reduced. These standards now also contain a cautionary labeling provision about scalding dangers. Moreover, the Commission initiated information and education activities to alert consumers to the possible hazard of tap water scalding.

The Commission is also working with the Community Services Administration in developing a pilot program for establishing criteria for upgrading the electrical systems in older homes of the elderly.

Another way the Commission works to assist the elderly is through the allowance of conventional packaging for products regulated under the Poison Prevention Packaging Act. This provision allows manufacturers to provide a conventionally packaged product for the aged and handicapped who may have difficulty with child resistant packaging. Elderly consumers or their physicians can also request that prescription drugs be packed in conventional packaging.

INFORMATION AND EDUCATION ACTIVITIES

The Commission develops programs, prints and distributes publications warning older consumers about potential hazards of consumer products and safe use of these products. Examples of the publications available for general distribution are: "Poison Prevention: Alternatives for Older Consumers and Handicapped," a fact sheet entitled "Older Consumers and Stairway Accidents," and a "Guide to Fabric Flammability." One of the CPSC films, "That Feeling of Falling," specifically addresses the hazards of the elderly falling against glass doors and their potential for suffering stairway accidents.

Several of our publications have been revised to make them easier for the elderly to read by enlarging the type, changing the format and eliminating the use of shiny print surfaces. Two examples of these in the Fire and Thermal Burn Area are, "It's Your Life . . . Don't Burn It Away," and "Guide to Flammability." The Commission expects to expand this technique in more of its publications. Other Commission publications directed to the general public also emphasize hazards to which older consumers are especially vulnerable, such as falls and scalds in tubs and showers and burns and fires from kitchen ranges.

The Commission's hotline, a toll free telephone system serving all 50 States including Puerto Rico and the Virgin Islands, gives many older consumers an easy opportunity to contact the Commission. This hotline provides safety information and recall warnings about potentially hazardous products to all consumers. The elderly population is active in using this facility. A teletype for the deaf and hard of hearing persons is available from 8:30 a.m. to 5 p.m. e.s.t. to those who call the hotline on special numbers.

The Commission's field offices have conducted a variety of information and education activities to increase the awareness of older consumers about potential hazards associated with consumer products. For instance, the Commission's Dallas regional office has initiated a survey to find better ways of reaching special target audiences, one of which is the elderly, regarding ways to improve the effectiveness of recalls of potentially hazardous consumer products. The elderly consumers surveyed were most helpful in identifying ways to reach their population group. This information has provided CPSC with new insight on ways to improve the content of recall messages so the public can more easily understand them and to encourage them to respond more quickly to the recalls.

The Commission's Kansas City regional office has maintained continuing cooperative relationships with State commissions on aging in that region with primary emphasis on poison prevention and fire and thermal burn problems. This overall cooperative endeavor has resulted in a number of workshops and meetings with elderly consumers and officials representing those consumers in Iowa and Missouri. In all instances, the emphasis of the presentations was on the CPSC visuals and printed materials which are specifically geared to the elderly.

Another project undertaken by the CPSC to find a better way of communicating with the public regarding product hazards is a 6-month fire safety pilot project designed to reduce fire incidents involving the elderly and low income groups. This program was launched in five communities located in the "fire belt" (an area extending from Oklahoma through North Carolina, including Alaska and the District of Columbia, identified in surveys as having a very high rate of fire incidence). Five community action agencies serving communities in this area received grants funded by the Commission to conduct fire safety information and education activities emphasizing hazards associated with flammable products and ignition sources. The Commission selected print and audio-visual materials for use in the project and requested that the agencies consider incorporating the materials into their on-going programs. The project will be evaluated by the Commission in fiscal year 1981. If it is found that the project contributed sufficiently to increased awareness of fire hazards, it may serve as the basis for the development of a model for conducting fire safety programs in similar communities.

ITEM 20. ENVIRONMENTAL PROTECTION AGENCY

JANUARY 2, 1981.

DEAR MR. CHAIRMAN: I am pleased to respond to your request of October 30, 1980, and inform you of the very successful older worker activities taking place at the Environmental Protection Agency (EPA).

The Senior Environmental Employment (SEE) Corps was created in concert with State environmental agencies and the financial aid of the Administration on Aging. The Corps has provided meaningful and part-time employment to several hundred older Americans in jobs relating to the prevention, abatement, and control of environmental pollution. The jobs include surveying toxic chemicals used in industrial areas, educating the public on areawide water quality planning, educating the public on programs in noise abatement, establishing and managing agency environmental libraries, presenting education programs on the use of pesticides and the hazards of poisoning to farmworkers, and working on surveys of environmental carcinogens.

Our Office of Monitoring and Technical Support has found that using older worker participation in crisis situations such as Three Mile Island and Love Canal lessens the problems of creating a special work force to meet such circumstances. Under the SEE Corps, qualified older workers can be recruited on short notice to assist in work to be done in similar crises.

Enclosed is an evaluation report of how the Office of Research and Development's national work force development staff and State environmental agencies together utilized the many and varied capabilities of the older workers for the benefit of the Nation's environmental quality. The older workers benefited by confirming their self-worth and by giving them the opportunity to contribute to the improvement and protection of the environment.

As a result of this success, EPA, the States, and the Department of Labor are working to expand the program into a Senior Environmental Employment Corps, as referred to in the Older Americans Act Amendments of 1978. The SEE Corps will ultimately operate in all eight environmental program areas and in all 50 States. In preparation for this development, EPA has funded a national pesticide use survey which will employ only senior workers to carry out a statutory program to document pesticides use patterns.

EPA has supported other activities of Title V: Older Workers Program in Florida, Alabama, California, Iowa, and Washington. In addition, the Agency has helped support a poison alert project staffed by older workers in the States of California, Washington, and Iowa. Other States were supported to conduct noise surveys and studies; and in Washington State, older workers are monitoring landfills to measure the gases seeping from underground to the surface.

We believe that the SEE Corps provides excellent opportunities for older citizens to participate in and benefit from the program while improving environmental quality for everyone.

Sincerely yours,

DOUGLAS M. COSTLE, *Administrator.*

Enclosure.

THE SENIOR ENVIRONMENTAL EMPLOYMENT PROGRAM—OUTCOMES AND PROSPECTS

PREFACE

In 1977, the Administration on Aging and the Environmental Protection Agency implemented a nationwide demonstration project—the senior environmental employment (SEE) program—in which over 200 workers aged 55 and above have been employed in a wide variety of jobs in the field of environmental quality. Over the past 3 years these older Americans have provided State and Federal environmental agencies with crucial assistance in areas such as water supply/

water quality, solid and hazardous wastes, air quality, pesticides, and noise control.

For the individual demonstration projects, the original SEE funding has been terminated. Several of these have been able to retain, at least temporarily, most or all of their SEE workers through alternative State or Federal funds. Other SEE projects, however, have been forced to shut down completely. The overall result has been unemployment for most of the SEE workers. There appears to be little prospect that many will be able to find new jobs comparable in satisfaction to those offered by the SEE program.

The SEE program was clearly a success in demonstrating the capacity of older workers to make a cost-effective contribution toward the prevention and abatement of environmental pollution. Many of the SEE enrollees performed at a level beyond their supervisors' initial expectations and often contributed time to their jobs over and above the hours for which they were actually paid. For many, the SEE program was not just a job but a new career, a fact which challenges the traditional conception of "retirement."

The application of the SEE concept to other agencies and programs has been limited to date, although several States that did not participate in the demonstration project have expanded the utilization of older workers in their environmental programs, and EPA itself has several SEE spin-off projects that are in various stages of planning or implementation. Application of the SEE concept should not be restricted to the environmental field, however, as there are shortages of skilled, experienced and highly motivated manpower in many other areas of public service employment. The fields of energy conservation, public health, consumer protection, recreation, and social services hold great promise for the development of SEE-type programs. It should also be stressed that the potential supply of older workers will greatly increase in the coming years, from 22.4 million Americans over 65 in 1975 to 31.4 million over 65 in 1995 (Bureau of Census estimates). If the SEE program is any indication, a large proportion of these citizens will offer and want to play a productive and socially meaningful role in their nation's economy.

The FAR professional staff who participated in our evaluation of the SEE program were John Faris, Paul Taff, Leo Kramer, and Gary Davis.

LEO KRAMER,
Director, Foundation for Applied Research.

I. STATUS OF THE INDIVIDUAL SEE PROJECTS

At the conclusion of the initial 2 years of the 11 SEE pilot projects, project directors held a strongly positive evaluation of the program. Two-thirds viewed it as "very successful," and the remainder regarded the program as "successful, with substantial room for improvement." Most (more than three-quarters) felt that the program in their States should be expanded; the others thought it should be retained at the present level.

Project directors were asked to provide some quantification, where possible, of the major accomplishments of the SEE program. Their responses are as follows:

Connecticut

Air quality

In the enforcement section, SEE staff were primarily responsible for scheduling field inspections, handling complaint response, and coordinating field staff schedules. The following numbers of inspections were scheduled on average per quarter (10/1/78–6/30/79):

Industrial inspections	600
Gasoline stations	600
Complaint response	180
Compliance inspections	45
Routine surveillance	120
Special surveillance	60

Solid Waste Unit (10/1/78–6/30/79)

Two SEE participants visited 71 towns and conducted surveys and completed survey reports on disposal areas within these towns. They also completed 90 site maps showing site boundaries, wetlands, water courses and structural features at each site.

Water Quality (Safe Drinking Water Program) (10/1/78-6/30/79)

During the first 9 months of fiscal year 1979, five field workers in this program completed the following:

Water samples collected	2,170
Resamples (of problem sites)	490
Special samples (on request)	1,774

Many of these samples were analyzed initially in the field by the SEE participants before being delivered to the State health department laboratory (such as pH tests, etc.).

Noise Control (10/1/78-6/30/79)

Responded to 34 complaints (25 resolved, 9 pending action). Thirteen on-site field inspections were also conducted during this period. In addition, the following training sessions were attended:

(a) Noise Control Seminar in Boulder, Colo. (10/9/78-10/13/78).

(b) A 1-day instrument seminar by Gen. Rad. Corp. (11/16/78).

(c) A 2-day instrument training session at the University of Massachusetts sponsored by EPA region I (3/22/79-3/23/79).

This SEE person also served as cochairman of an all day seminar at the University of Hartford sponsored by University of Hartford and EPA region I, which concerned Connecticut's noise control program and legislation. This was attended by many town officials from Connecticut.

Land Acquisition (10/1/78-6/30/79)

One SEE member processed 26 letters of credit payment requests totaling over $4,000,000.

A second member conducted 50 preliminary site inspections prior to acquisition which included inspection of property, boundaries, legal status and title, local land records, etc.

The third member actively negotiated for the purchase of seven land sites for the State (totaling over 459 acres) for future use as State parks and forests.

Information and Education (10/1/78-6/30/79)

Processed over 480 film library loan requests.

Completed a 5-year index of the Department's monthly newsletter.

Cataloged over 600 books.

Completed a file system for periodicals, reference materials, and educational materials.

Wrote one article per month for the Department's monthly newsletter including two feature articles.

Water Quality (Construction Grants Program) (10/1/78-6/30/79)

One SEE participant processed and reviewed 14 construction contract awards valued at over $8,195,930 and also processed nine payment requests.

New Jersey

As of August 30, 1979:

—6,505 industrial sites visited, 2,603 of which were identified as hazardous waste generators. These have all been included on the computerized "manifest" (waste-tracking) system. SEE personnel have assisted with the implementation of the system.

—1,003 DEP employees have been trained in defensive driving. By having this mandated training done by a SEE employee, over 15,750 has been freed-up for expenditures relating to technical (environmental) training.

—Technical training records were compiled and verified for DEP's 2,400 employees.

—Thousands of registration forms for Safe Drinking Water Act Seminars for plant operators and engineers were processed and all attendant administrative work performed by one SEE employee.

Pennsylvania

The major accomplishment of SEE workers has been the completion of the closed dump site inventory in the areas worked by SEE staff. As a result of the survey activities, several closed dump sites were shown to be active and actions to close them have been initiated. Ninety percent of the municipal waste water treatment plants in western Pennsylvania were surveyed to determine details of sludge disposal techniques employed. Public information presentations were given in two service areas by SEE workers when regular staff were not available.

Kentucky

There were 197 business surveys done for unregistered pesticide products. Six unlicensed pest control operators were uncovered.

Out of an estimated 2,500 open dumps in the State, the SEE program employees located 1,004.

Kansas

We were able to take our 208 proposals to the citizens of Kansas with much greater success than we would have if we had not used SEE workers.

In our water supply program the SEE workers have located some 1,100 noncommunity water supplies. At this time they have covered about two-thirds of the State.

South Dakota

Investigated 117 individual wastewater complaints; inspected 200 noncommunity water supplies; closed 25 disposal sites; discovered five hazardous waste sites; and inspected 300 grain elevators. Performed sampling for the 208 water quality management program and monitoring for water quality study areas. Also assisted the health department in medic preparation, glassware preparation, and receiving and mailing sampling kits.

Other statements of the accomplishments of the SEE program include:

Arkansas

Public awareness relating to the seriousness of solid waste.

Public response to keep waters clean and free of foreign agents.

The asbestos program was fantastically received by all citizens and received all statewide TV and press coverage. Extremely expensive airtime was voluntarily offered to this interest.

California

Our local SEE program, being an educational and/or information and pesticide accidents reporting program, has been very successful in accomplishing these objectives. As a result, it has helped also in the protection of the environment by reporting improper disposal of empty pesticide containers and reducing the usage of them by people who do not realize the danger.

Noise Program

In the Boston EPA Regional Office, the SEE program employee was responsible for the development and implementation of the new ONAC grant program for State and local noise control projects. The same situation was the case in the Atlanta EPA region.

In the Seattle EPA Regional Office, the SEE employee is the former executive director of the State Municipal League. He is often called upon by the EPA Regional Administrator to provide information and analysis relative to the political climate of Washington State and local governments with respect to all environmental programs—not just the noise program. This person also provides valuable liaison between EPA's Regional Administrator and units of local government within the State.

In the San Francisco EPA Regional Office, the SEE employee is a renowned expert in acoustics and serves as a regional expert on noise and noise issues. He also serves the region in complex local noise problems and gives presentations on noise and acoustics throughout the region.

In the Denver EPA Regional Office, the original SEE employee has been placed in a permanent part-time GS–11 Federal position within the Regional Office of Public Affairs. The Regional Administrator utilizes this individual's writing talents extensively for papers and speeches. This former SEE employee often accompanies the Regional Administrator to State and local events within the region.

Several SEE employees manage the ONAC equipment loan program which is designed to assist States and locales with their noise problems by providing the necessary equipment for them to take noise measurements within the jurisdictions. They also provide training on the use of the equipment.

All of the SEE employees are involved in the ONAC ECHO (each community helps others) program—a high priority ONAC program which initiates self-help activities between and among States and local governments with respect to noise control.

Several of the SEE employees are educators who take an active part in school noise programs as well as in public information/education components of the regional noise program.

In six of the individual projects (Connecticut, New Jersey, Kentucky, Arkansas, Washington, and the noise program), one or more of the SEE workers were retained through alternative funds when the original funding was exhausted. Three of these projects (Connecticut, Kentucky, and the noise program) were able to retain, at least temporarily, most or all of their SEE workers. In the other projects, however, termination of funding resulted in termination of employment for all of the SEE workers. The employment status of the SEE workers subsequent to termination of Federal funding is addressed in the following sections.

II. POST-SEE EXPERIENCE OF SEE WORKERS

Following the termination (and subsequent exhaustion) of Federal funding to the SEE program, the Foundation for Applied Research surveyed the former SEE workers regarding their present employment status and attitudes toward their participation in the SEE program. As with previous surveys of SEE workers, FAR obtained an extremely high response rate, approximately 95 percent. Most (54 percent) of the responding SEE workers were unemployed at the time of the survey; a substantial number (27 percent) were employed in the same job they had while under SEE funding; and 15 percent had found new employment. Only 4 percent considered themselves to be retired.

As table 1 shows, post-SEE employment status is not strongly linked to age.

TABLE 1

[In percent]

	Age					
	55–59	60–64	65–69	70–74	75 or over	Tota
Employed in same job	20	38.5	29.4	21.1	9.1	27
Employed in different job	20	7.7	14.7	21.1	18.2	15
Unemployed	60	46.2	52.9	52.6	72.7	54
Retired	0	7.7	2.9	5.3	0	4
N	(1)	(26)	(34)	(19)	(11)	(100)

Younger SEE workers (under 65) were only slightly more likely than others to be retained in their environmental jobs. All age groups had a high rate of unemployment; younger workers did not appear to have an easier time in finding alternative employment. It should be noted that many of the SEE workers were surveyed shortly after termination of their SEE employment; it is reasonable to expect that the percent unemployed should decrease. Several of those who did find jobs following termination from the SEE program indicated that their participation in SEE had helped in locating their new job. This help included recommendations from supervisors, an expanded range of contacts, and development of new marketable skills.

The majority of former SEE workers felt that the SEE program was valuable and felt that they had personally benefited by participating. Over 80 percent felt that the SEE program should not have been terminated but should have been expanded and made permanent. The others recommended that the program be retained with substantial changes. None felt that it should have been terminated. Their comments indicated that their approval of SEE was based on the conviction that SEE made a valuable contribution to protecting and improving the environment:

> I feel the good the SEE program has done toward improving our environment should call for a permanent program of this type.
>
> I think the SEE program was a good one and very important to the health and well-being of people of all ages.

> The people in the counties that I contacted realized that the program was important to their health and the improvement of their community as well.
>
> There is no question that the environmental work is needed and that in most cases the individual States do not have fast enough or efficient enough implementation for sufficient environmental employees.
>
> This program did a great job while it lasted by providing the government with seasoned and valuable personnel, most of them willingly working below their monetary worth. I was personally acquainted with most of our 20 SEE workers and can testify to their industry and integrity.
>
> There is so much pollution in this country that the SEE program should never have been terminated.

Former SEE workers were asked what effect their participation in the program had on their lives. Over 90 percent indicated a positive effect; most of these (75 percent of all respondents) regarded nonfinancial benefits as the most important effect:

> It made me feel that I was worth something and could accomplish something in my life at this age and helped me very much in my health condition. I felt very good at the time.
>
> Gave me a feeling of being useful. Made me feel like a person again. I felt like living and doing things. Nothing is harder on a person then being retired and put on a shelf and forgotten.
>
> It gave me an opportunity to meet a great number of people and see what problems exist in the environment.
>
> Provided an opportunity to use skills which since retirement were to some extent idle. Provided a sense of need, duty and the realization that I was accomplishing something of importance.
>
> The SEE program provided me with the most enjoyable working experience in my lifetime.
>
> One of the most rewarding experiences of my life. Made new friends. Learned about government, politics, and environmental problems. Very stimulating activity, and won recognition of department head and Commissioner.
>
> Confirmed self-worth—established confidence—regained esteem of family and friends (so fragile for a retiree).

The responses of former SEE workers to the question of the impact of SEE participation on their lives are grouped according to present employment status in table 2.

TABLE 2

[In percent]

Effect of SEE program on life	Employment status: Employed in same job as in SEE program	Employed in new job	Unemployed, seeking work	Retired	Total
Positive—Financial	25.9	0	13.5	0	14.5
Positive—Other	66.7	78.5	84.6	75	78.3
None or negative	7.4	21.5	1.9	25	7.2
N	(27)	(14)	(52)	(4)	(97)

A solid majority of all four categories of former SEE workers—retained in the environmental job, working in a new job, unemployed and seeking work, or retired—regarded their participation in SEE as having had a positive impact on their lives which was principally of a nonpecuniary nature.

It is interesting to note that this effect was as strong (if not stronger) among those who were unemployed following termination from SEE (84.6 percent reported a nonfinancial positive effect) as among the others. It is evident from the survey comments of former SEE workers that many retain their positive assessment of the effect of SEE participation despite sharp disappointment at the termination of funding and, in some cases, depression at having lost the useful and active role which SEE provided.

Analysis of the effects of SEE participation on workers' lives by age and type of SEE job yielded similar results. Regardless of age group or type of job—office or field, technical or clerical—the majority of SEE workers in all categories felt that the principal benefit of the SEE program was not financial but was a result of being involved in useful and interesting activity. This feature of the SEE program clearly seems to be linked to the high motivation of the SEE workers and the supervisors and project directors in the environmental agencies.

III. DISSEMINATION OF THE SEE CONCEPT

As part of FAR's research to determine the long-term impact of the senior environmental employment program, a questionnaire survey was sent to selected officials (typically the personnel officer) in the environmental agencies of the 40 States not included in the SEE demonstration project. The initial mailing was followed by a reminder to those who did not respond initially. Through use of telephone interviews (after two mailed followups), a 100 percent response rate was achieved. Following a brief description of the SEE program, respondents were asked if they had previously heard of the program. A substantial number (35 percent) responded affirmatively. Most of these had heard of SEE through contact with the Federal Environmental Protection Agency, in most cases through an EPA regional representative. All of those who had heard of SEE who reported an impression of the program had a favorable impression, e.g.:

> Excellent program.
>
> The concept is excellent. It provides an opportunity for less employable people who have a great deal of usable expertise and who are willing to work.
>
> Good concept. Very limited application caused by salary and population guidelines.
>
> This program seems to be a useful way to involve experienced older persons in environmental programs—taking advantage of their knowledge and skills, in addition to providing some possibility for employment of underemployed older Americans.

Respondents were invited to indicate a desire for more information on SEE. About two-thirds, including those who had already heard of SEE, would like to have more information on SEE.

Nine of the forty respondents indicated that one or more environmental agencies in their States has a program designed to recruit and employ older workers. At least four of these (in South Carolina, Iowa, Arizona, and Florida) were a direct result of the SEE program. On the less positive side, the survey results indicate that, in 31 of the 40 non-SEE States, there was no program to increase the utilization of older workers in the environmental field.

The survey results indicate that there is a large potential for increased utilization of older workers in the environmental field. Respondents were asked if they saw any potential for future application of the SEE concept. A strong majority (84.4 percent) of those who answered replied in the affirmative, e.g.:

> We are usually understaffed in the engineering/technical sections, air, solid waste, water quality.
>
> Perhaps in food protection and hazardous waste.
>
> The county health departments could use talented older workers in enforcing and establishing these programs. We will undoubtedly have numerous special projects which will offer limited employment to these people.
>
> In offices requiring clerical skills such as filing and typing. Some positions are seasonal such as inspection of swimming pool, collecting water samples.
>
> Possibly a program could be developed to provide assistance in the area of proofreading or administering questionnaires which involve environmental programs, such as the 208 water quality management program.
>
> We could use additional staff in water quality control, toxic materials control, solid waste management, and air quality control.
>
> All environmental programs need people with knowledge and experience. It is difficult to find those people who will work for lower pay than their private sector counterparts.
>
> Both the State and local pollution control agencies could, if funds were available, substantially increase their present service to the public—these agencies have been chronically understaffed. Additionally, there is a need for part-time water supply and waste water system operators in rural areas that might be met, in part, by older workers.
>
> Yes, there are areas of potential benefit in a variety of environmental programs, e.g.: water supply/pollution, air pollution, noise, radiation, solid wastes and hazardous material, vector control. Matching of a senior citizen's background and experience to any of the above programs would be helpful.

> Individuals with backgrounds in maintenance and operation of industrial manufacturing equipment would be of value for in-plant inspections of pollution control equipment.
>
> We could use assistance, funds permitting, in the entire spectrum of environmental control programs. We are desperately in need of professional staff in our water and air pollution control programs as well as our solid waste and hazardous waste activities. Ad hoc assistance would be helpful in our pesticide noise, institutional sanitation, radiation, and other activities.

It is quite evident from the above that while the majority of States not involved in the initial SEE demonstration program do not have any program to increase the utilization of older workers, most of these States indicate a significant potential for such utilization.

The SEE program has resulted in the planning of several new EPA programs designed to utilize older workers. These programs, in varying stages of planning and implementation, are a direct consequence of the success of the SEE program in demonstrating the value of the older worker in environmental work. They include:

1. Senior environmental employment program for asbestos control training. Ten older workers are being trained for assignment to the regional offices of toxic substances to assist in developing and implementing a program to inspect and control asbestos in schools. This program is being administered by NRTA/AARP.
2. National pesticide usage survey. This program, also administered by NRTA/AARP, may eventually enroll 100 older workers for a national survey of nonagricultural pesticide usage. Several older workers have been hired for a pilot study. Implementation of this project has been delayed pending approval by the Office of Management and Budget of the proposed survey form.
3. Hazardous waste monitoring project. Modeled after the New Jersey SEE project, this project may eventually provide employment for 10 older workers in each participating State. The project is in the planning stage. Funding, half of which is to be provided by EPA and half by title V, is uncertain.
4. Project to distribute literature and provide training on auto emissions control. EPA hopes to put one older worker in each State and in each regional headquarters in the project. It is in the early stages of planning.
5. Senior environmental employment noise program. The original noise program, which has continued and may be made permanent, now has several spinoffs. Twenty older persons are now working as noise counselors in local governments. (Half of these are administered under a grant to NRTA/AARP and half through a grant to the National Urban League). Also, the number of older workers in the noise program at the Washington, D.C., EPA office has been expanded.
6. EPA has also provided funds (for travel, administration, equipment, etc.) to support various State and regional environmental programs employing title V older workers (e.g., in Florida, Iowa, Kansas City, South Carolina). As an example, EPA has paid for the monitoring equipment needed by title V older workers in region VIII and Bremerton, Wash., who are measuring potentially hazardous methane emissions from sanitary landfills.

Dissemination of the SEE concept has proceeded in varying degees. The greatest acceptance and appreciation of the value of utilizing older workers in public service employment has been at the Federal level of the Environmental Protection Agency and in the 10 SEE States. It is important to note that those State SEE programs (Connecticut, New Jersey, Kentucky) in which older workers were placed in diversified positions directly within the State environmental agencies (as compared to the special project approach in States such as Pennsylvania and Arkansas) have a much higher rate of retention of SEE workers in the environmental positions following termination of SEE funding. In the 40 non-SEE States, as the survey results indicate, dissemination of the SEE concept is very limited, though there exists great potential for the utilization of older workers in these States. Further, perhaps the greatest potential for dissemination of the SEE concept remains almost completely untapped. This is the utilization of older workers in SEE-type projects in public service employment (such as in energy conservation and weatherization) outside the field of environmental work. The Foundation for Applied Research regards the viability and value of the SEE concept—both from the point of view of the older worker and from the point of view of the employing agency—as amply demonstrated. It is equally clear that the dissemination of the SEE concept is far from what it should be and that this should be an urgent priority before the SEE experience becomes just a set of old memories.

IV. SUMMARY AND CONCLUSIONS

From the perspectives of both Federal sponsors, the Administration on Aging and the Environmental Protection Agency, the senior environmental employment program was successful. The pilot projects showed that older persons could be employed in a wide variety of environmental positions on a cost-effective basis. SEE workers performed an impressive number of measurable contributions to protecting and improving the quality of the environment. At the same time, the SEE workers benefited significantly from their participation, in part through the additional income derived from their employment, but even more from the intrinsic satisfactions of being involved in interesting and worthwhile activity. A substantial number of SEE employees were retained within State or regional environmental agencies after the termination of Federal funding; most of the others are seeking to remain active. Nearly all of the SEE workers regarded their experience in SEE as being very positive, often despite feelings of disappointment at the termination of the program.

In order to be successful, the SEE program had to overcome at least two types of obstacles—attitudinal and structural. With regard to the first type, the majority of project directors from State environmental agencies were highly skeptical of the efficacy of the SEE concept at the beginning of the program. Further, there were indications that other environmental officials not involved with SEE were, and are, even more resistant to the idea. In the case of the SEE project directors, this skepticism was overcome by the success of the program and the effectiveness of the SEE workers.

A second type of obstacle to the SEE program was structural. In many States, there were problems in fitting SEE workers into the administrative and financial structure of the environmental agency. In some cases (New Jersey, for example), SEE workers were paid by the State as hourly workers but did not qualify for fringe benefits. In other States, the administration of SEE was undertaken by a third party (Green Thumb, NRTA/AARP) which effectively resolved the structural problems. In still other cases (Connecticut, for instance), new job titles were created and variances granted to permit the inclusion of fringe benefits to SEE workers. In at least one State, such bureaucratic obstacles appeared to be insuperable, and the State was forced to withdraw its grant application.

The obstacles which confronted the original SEE projects may be significant factors in the slow pace of development of new applications of the SEE concept. While some spin-offs have appeared and others are being planned, it remains the case that the potential utilization of older workers in the environmental field is far from being realized despite the demonstrated success and cost effectiveness of the SEE Program. Publicity is not sufficient. What is needed are presentations of documentary evidence to overcome skepticism and suspicion and technical assistance to cope with administrative bureaucratic obstructions. Priority should now be given to initiatives which would capitalize on the success of SEE and effectively stimulate an expansion of valuable employment opportunities for older Americans.

ITEM 21. FEDERAL COMMUNICATIONS COMMISSION

JANUARY 16, 1981.

DEAR SENATOR CHILES: This is in response to your and Senator Domenici's letters of October 30 and November 26, 1980, which requested fiscal year 1980 information regarding initiatives or programs by this Commission that impact either directly or indirectly on the elderly. Such information would be included in part 2 of your committee's next periodic report of "Developments in Aging," scheduled for publication in February 1981.

The Federal Communications Commission has the mandate to regulate communications "* * * so as to make available, so far as possible, to all the people of the United States a rapid, efficient, nationwide, and worldwide wire and radio communication service. * * *" 47 U.S.C. § 1. Consequently, our actions are generally broadly based and do not focus directly upon the needs of the elderly.

During the past several years, this Commission has assisted in the initiation of efforts to provide closed captioning of television for the Nation's deaf and hearing impaired. Since a significant proportion of all persons with bilateral hearing losses are aged 65 or older, consideraton of telecommunication needs of the deaf is a matter of interest to the elderly, although not specifically directed to the elderly.

Following the Commission's grant of authority in 1972 to the Public Broadcasting System (PBS) to initiate experiments in closed captioning and the Commission's adoption of rules in 1976 to permit closed captioning on the vertical blanking space of line 21 of the television broadcast signal for the transmission of captioned information for the deaf, PBS and the National Bureau of Standards, with funding provided by the Department of Health, Education, and Welfare (HEW), worked together on the development of the closed captioning technology. As announced by HEW on March 23, 1979, a closed captioning project was initiated to include: (1) The provision of a total of up to 20 hours of captioned programing a week by PBS, ABC, and NBC, (2) the provision of special decoding devices by Sears, Roebuck & Co., and (3) the establishment and funding of a nonprofit National Captioning Institute by HEW to caption programs for the television networks.

On April 5, 1979, the Commission held an open, public meeting to receive a comprehensive briefing on the status of the closed captioning project by representatives of ABC, NBC, PBS, and HEW. The Commission later stated in regard to that meeting:

> We expect that the closed captioning project will be a success. However, if at a later date it is demonstrated that the project is not successful in making television programing more available and enjoyable to the hearing impaired, then it may be necessary for the Commission to determine if a rulemaking is warranted to insure that the hearing impaired are not deprived of the benefits of television.

Additionally, the Commission is currently analyzing responses to its February 1978, notice of inquiry regarding the provision by communications common carriers and equipment manufacturers of communications equipment for the deaf and hearing impaired. As in the case of closed captioning for television, we anticipate that the information assembled by this inquiry will be of interest to the elderly, although not specifically directed to the elderly. Tactile paging is an example of a service proposed in this inquiry that will help the elderly especially, though not exclusively. The Commission reallocated two low-band radio channels on November 18, 1980. They will be used in part for paging a deaf, blind, or otherwise handicapped person by means of a device that vibrates. The paged person will be able to use the device to transmit an acknowledgment.

Finally, this Commission regularly receives from the elderly which urge relaxation of the international Morse code speed requirements for operator licenses in the amateur radio service. Recognizing that the Commission is currently precluded by article 41, section 3(1) of the ITU radio regulations from waiving or eliminating the telegraphy requirement in its entirety, the Commission in August 1978, sought public response to this issue as part of its notice of inquiry regarding the administration of telegraphy examinations to handicapped applicants for operator licenses in the amateur radio service. The Commission's staff analyzed responses to this notice of inquiry, and the Commission's delegation to the 1979 World Administrative Radio Conference at Geneva proposed changing the requirement of article 4, section 3(1) of the ITU radio regulations to a less restrictive recommendation which would allow the United States future flexibility in the development of licensing requirements in the amateur radio service. WARC rejected the proposal in pertinent part.

It must be noted that many elderly handicapped people are among the amateur radio licensees opposing relaxation of the speed requirements, notably that the licensee be able to receive Morse code at five words per minute. Regarding procedure, the Commission is considering amending the rules to let candidates, including the elderly and hearing impaired, take the test by sight or by touch, not only by sound.

Other than the efforts described above, the Commission has not expended funds during fiscal year 1980 on specific programs for the elderly, nor are we aware of any court decisions or litigation which would directly affect our concern for the elderly.

I hope this information will be of assistance to your committee.

Sincerely,

CHARLES D. FERRIS, *Chairman.*

ITEM 22. FEDERAL TRADE COMMISSION

JANUARY 15, 1981.

DEAR MR. CHAIRMAN: I am pleased to report to you on the Commission's activities for fiscal year 1980 which affect the elderly. While virtually all of the Commission's efforts to promote a free and fair marketplace may benefit older persons, many of our activities are of particular significance for the aged. A staff summary of those activities is enclosed.

If we can be of further assistance to the committee, we hope you will call upon us.

By direction of the Commission.

MICHAEL PERTSCHUK, *Chairman.*

STAFF SUMMARY OF FEDERAL TRADE COMMISSION ACTIVITIES AFFECTING THE ELDERLY

VISION CARE

Over 90 percent of persons over the age of 65 wear corrective lenses. The FTC has two programs designed to lower the price of vision care. The first, the "Eyeglasses Rule," gives consumers the right to obtain a copy of their prescription after having their eyes examined, thereby enabling them to comparison shop for eyeglasses. A portion of the rule which eliminated restrictions on advertising of eye care goods and services was remanded by the U.S. Court of Appeals for the District of Columbia Circuit in February 1980. The rule was remanded so that the Commission could consider whether the regulation is necessary in light of recent Supreme Court decisions regarding constitutional protections for advertising by professionals. The Commission's staff is collecting evidence to determine whether any further Commission action regarding advertising is appropriate.

The second vision care program, known as "Eyeglasses II," is examining several proposals aimed at increasing competition and lowering prices in the vision care market. One portion of the investigation is focused on restrictions which inhibit so-called commercial practice of optometry, including restrictions which prevent optometrists from practicing under a trade name, working for a lay corporation, locating their practice in a commercial location, and operating branch offices. In addition, the FTC is examining staff proposals to expand the prescription release requirement contained in the Eyeglasses I Rule. These proposals would give consumers the right to: (1) Retain a copy of their eyeglasses prescription after it is filled; and (2) obtain a copy of their complete contact lens prescription at the conclusion of the fitting and dispensing process. These proposals would enable consumers to comparison shop for duplicate or replacement pairs of eyeglasses or contact lenses.

DENTAL CARE

Slightly over half of all persons over age 65 have lost their teeth, and approximately half of this group needs denture care, either because they have no dentures at all or because the dentures they do have are so ill-fitting as to be beyond repair. The high cost of denture care and the maldistribution of dentists in certain parts of the country (most notably in rural and inner-city areas) may prevent many elderly consumers from obtaining denture care. Preliminary evidence from Canada suggests that consumer costs may decrease and access to denture care may increase where dental laboratory technicians, known as denturists, are permitted to provide dentures directly to consumers. In the United States virtually all States prohibit nondentists from selling dentures directly to patients and require that dentures be fitted only by dentists. The FTC is gathering evidence to determine the potential effects on consumers of permitting denturists to offer their services directly to the public.

PRESCRIPTION DRUGS

Persons over the age of 65 comprise 11 percent of the population, but pay 25 percent of the national prescription drug bill. Consequently, savings on prescription drug purchases are especially significant for elderly consumers. The FTC staff has examined State laws which prevent pharmacists from substituting lower

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cost generic drugs, and has concluded that modification of these State laws could result in significant consumer benefits, with no compromise in the quality which consumers receive. The Commission's staff, in conjunction with the Food and Drug Administration, has proposed a model drug product selection statute for consideration by the States, and the staff is providing assistance to States contemplating legislation on this issue.

HEARING AIDS

The majority of hearing aids are purchased by the elderly. Statistics indicate that over 40 percent of persons over 65 have some type of hearing impairment. In 1975, the Commission began a rulemaking proceeding dealing with the advertising and sale of hearing aids, and in 1979 proposed an enactment of a trade regulation rule which would give the consumer a right to return a hearing aid and obtain a refund after trying it for 30 days. The principal purposes of this provision are to discourage manufacturers and sellers from overstating the value of the hearing aids, to discourage high pressure sales tactics, and to protect consumers from the risk inherent in the purchase of a hearing aid that the aid will not provide a benefit.

COMPETITION IN THE HEALTH CARE SECTOR

The following projects are aimed at preventing anticompetitive conduct in the health care industry. Their purpose is to stimulate and strengthen competitive forces in the industry, thereby decreasing the need for government regulation, increasing consumer choice among providers of health care services, and lowering the cost of health care. Consumers age 65 and older spend almost three times as much on health care per capita as do consumers aged 19–64. Given the fixed income status of many persons over 65, these Commission initiatives may have a significant impact on elderly consumers.

American Medical Association (AMA).—In October 1979, the Commission issued a decision in its case against the AMA. The Commission found that the AMA had imposed illegal restrictions on truthful advertising by physicians and medical organizations and on the ability of physicians to work on a salaried basis for hospitals and health maintenance organizations. The Commission ordered the AMA to stop imposing such restrictions. Pursuant to the decision, physicians will be able to provide consumers with truthful information about the services they offer, and hospitals and HMO's will be able to seek to hold down costs by employing physicians on a salaried basis. The Commission's order expressly provides that the AMA may adopt reasonable ethical guidelines to prevent false and deceptive advertising. The Commission's order was upheld, with minor modifications, the U.S. Court of Appeals for the Second Circuit in October 1980.

Blue Shield and certain other prepayment plans.—This matter consists of a comprehensive review of the role of physician organizations in controlling Blue Shield plans—the largest source of private insurance for payment of medical bills. Commission staff analyzed the operation and control of the 70 Blue Shield plans to assess whether dominance of their operations by physician groups has any impact on increasing physicians' fees or on discrimination against nonphysician providers. An econometric study by the Commission's Bureau of Economics indicates that Blue Shield plans which are controlled by representatives of medical societies may have higher reimbursement rates than other Blue Shield plans.

The Commission has solicited public comment concerning the possible initiation of a rulemaking proceeding to consider limiting or prohibiting participation in control of Blue Shield and certain other open-panel medical prepayment plans by physician organizations. The Commission is currently considering this and other possible courses of action.

Indiana Federation of Dentists.[1]—On October 18, 1978, the Commission issued a complaint alleging that the Indiana Federation of Dentists obstructed cost-containment measures instituted by insurers. An initial decision ordering the dentists to stop collectively refusing to supply X-rays used by the insurance companies in making reimbursement decisions is currently on appeal to the Commission.

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[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

Michigan State Medical Society.[1]—On July 27, 1979, the Commission issued a complaint alleging that the society's members conspired to fix prices and to boycott cost-containment procedures instituted by the Michigan Blue Shield Plan. The trial of this case has been completed and an initial decision is expected in 1981.

Sherman A. Hope, et al.—On July 30, 1980, the Commission issued a complaint charging the five doctors practicing in Brownfield, Tex., with threatening to boycott the local hospital if it hired a new doctor on financial terms unacceptable to them. The hospital, the only one in the county, had tried to recruit a new doctor into the area by offering him a guaranteed minimum income. According to the complaint, the doctors threatened not to perform their emergency room and administrative jobs at the hospital and not to deal professionally with the new doctor. The complaint has been withdrawn from adjudication while the Commission considers a proposed consent agreement.

MOBILE HOME SALES AND SERVICE

Mobile homes comprise a substantial portion of the low- and moderate-income housing stock, and a large proportion of mobile homeowners are elderly persons. In August 1980, the FTC issued a staff report recommending adoption of a proposed trade regulation rule designed to improve warranty service on mobile homes. Although nearly all new mobile homes are sold with a written warranty, evidence gathered in this rulemaking proceeding indicates that service under these manufacturers' warranties is inadequate, delayed, or simply refused for as many as 40 percent of owners of new mobile homes who request such service. In its report, the staff recommended a rule that would set 30-day time limits within which mobile home manufacturers or their service agents must complete warranty repairs, and would require them to perform preoccupancy inspections of the home. In addition it would require that manufacturers enter into written service agreements with dealers and others who perform warranty repairs.

CREDIT

The FTC enforces the Equal Credit Opportunity Act, which prohibits discrimination on the basis of a number of factors including age. While Federal law permits a creditor to consider information related to age, credit cannot be denied, reduced, or withdrawn solely because an otherwise qualified applicant is over a certain age. Furthermore, retirement income must be included in rating a credit application and credit may not be denied or withdrawn because credit-related insurance is not available to a person of a certain age.

NURSING HOMES

It has been estimated that three-fourths of all nursing home residents are 75 years and older. The FTC staff has been examining the business practices of nursing homes as they affect the approximately one-third of the Nation's nursing home residents who pay directly for their own care. Although the industry is heavily regulated by Federal, State, and local governments, these regulations generally focus on health and safety rather than consumer issues. Staff is particularly interested in the information disclosed to residents before entering a home and the fairness of nursing home admission contracts.

MEDICARE SUPPLEMENT INSURANCE

More than 50 percent of the Nation's elderly have at least one private health insurance policy to supplement their medicare coverage. Consumers have complained about a variety of problems connected with the sale of medicare supplement insurance, including: Confusing policy provisions which inhibit effective comparison shopping; exploitative sales practices which focus on the special vulnerability of the elderly; the sale of policies which duplicate existing coverage; and low rates of return (expressed as the ratio of benefits paid to premiums collected). In 1979, the FTC initiated a study to determine what types of regulatory schemes are most effective in combating these problems. FTC staff is now cooperating with the Department of Health and Human Services in a major study of State medicare supplement regulations.

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[1] This matter is currently in litigation, and the Commission expresses no view whatever as to the merits of the case.

FUNERALS

Since 1975, the FTC has been conducting a rulemaking proceeding which could affect the almost 2 million persons who arrange funerals each year, including numerous elderly citizens. The Commission tentatively approved in substance a proposed rule in March of 1979. Subsequently, specific limits were placed on the scope of any final rule by the FTC Improvements Act of 1980. The act required that the funeral rule be revised in accordance with these limits and that the revised rule be published for public comment prior to determining whether or not to adopt a final rule. In January of 1981, the Commission will publish a revised rule for a 60-day public comment period. A 20-day rebuttal period and opportunity for oral presentation will follow the written comment period, with final Commission action on the rule expected this spring or early summer.

The revised funeral rule is intended to create a marketplace environment in which consumers will have access to accurate information prior to and at the time of purchase. The rule would: Require funeral directors to disclose itemized price information; prohibit misrepresentations of legal and cemetery requirements and the preservative or protective value of embalming, caskets and vaults; prohibit funeral directors from engaging in certain practices such as requiring a casket for cremation and embalming without express permission; and prohibit boycotts and threats by funeral providers against others.

DELIVERY OF LEGAL SERVICES

The Commission's staff is currently conducting an investigation to determine whether various public and private restrictions have hindered the development of legal clinics and closed-panel third-party payment plans for legal services. Legal clinics and closed-panel plans reputedly offer reduced fees and increased access to high quality legal services. These advantages may be of particular benefit to the elderly, whose income often exceeds limits established by government-sponsored assistance programs, yet may be insufficient to cover the high costs of private bar assistance.

U.S. SAVINGS BONDS

In response to a complaint by the Gray Panthers, FTC staff met with Treasury Department officials to discuss advertising of U.S. savings bonds. The Gray Panther complaint alleged that the Government's advertising was unfair and deceptive because of its failure to disclose the adverse impact of current inflation on a savings bond investment. In cooperation with the FTC staff, the Treasury Department rewrote its savings bonds ads to remove any implication in the ads that savings bonds are a highly profitable investment and hedge against inflation.

ITEM 23. LEGAL SERVICES CORPORATION

JANUARY 7, 1981.

DEAR MR. CHAIRMAN: In response to your letter of October 30, 1980, the Legal Services Corporation is pleased to report on the services and benefits offered by our organization to older Americans.

As you know, the Legal Services Corporation was established by Congress in 1974 to provide financial support for civil legal assistance to poor people. The Corporation presently funds over 300 legal services programs around the country which provide legal assistance to the general poverty population. Because the elderly are found in disproportionate numbers within the poverty population, they are a major target for the provision of legal services.

Eligibility for legal services is governed by income and resources. The Corporation, as required by statute, has established a maximum income level for the receipt of legal services—125 percent of the OMB poverty line—and has set forth factors which local programs must take into consideration in developing their own eligibility guidelines. Within these parameters, each program has established procedures for determining the eligibility of applicants for legal services.

Similarly, priorities for the types of legal problems which will be addressed by local programs (again, within the parameters of the Legal Services Corporation Act and regulations) are determined on a local level, based on the legal needs of the particular community to be served. Thus, although the elderly poor are generally eligible for Corporation-funded legal services, one must look to the specific program's guidelines as to the types of cases handled and the actual financial eligibility requirements for that particular area.

While most local legal services programs do not exclusively serve older Americans—the elderly poor are served along with all low-income persons—many programs are beginning to identify separate units to address the special legal problems of the elderly. This has often been made possible through the joint funding of such specialized elderly units by the Legal Services Corporation and the Administration on Aging. The Older Americans Act funding has enabled the legal services programs to undertake additional efforts on behalf of the elderly such as outreach and community legal education with a concomitant increase in the quantity and quality of services to the elderly.

The Corporation also funds the National Senior Citizens Law Center, a national backup center to provide support and technical assistance to local program staff on the legal issues unique to the elderly population. The center has provided training, developed manuals, and established a network of elderly advocates and clients. The center undertakes impact litigation on elderly issues as well as providing administrative and legislative representation on these issues in Washington, D.C. The center also communicates on a regular basis with the elderly network to keep them informed of the latest developments in elderly law.

Recently, the Legal Services Corporation conducted a nationwide study of the special legal problems of the elderly and of their special problems in obtaining access to legal services. The results of this study are included in the enclosed summary report and shall guide the Corporation's future plans for meeting our goal of providing high quality legal assistance and assuring equal access to our system of justice for the redress of grievances for those otherwise unable to afford adequate legal counsel.

Although actual expenditures on service to the elderly are difficult to determine with any precision, statistics gathered during the above-mentioned study do provide a basis for comparison. The study found that the median program had a caseload containing 13.9 percent elderly clients. During the fiscal year 1980, the Corporation operated on a budget of $300 million. Approximately 2 percent of this budget is utilized for national administrative costs with the remainder going to field programs and field program support.

Your letter also requested information regarding interagency agreements. In 1977, the Corporation and the Administration on Aging (AoA) entered into an agreement, the purpose of which was to encourage cooperative relationships between the Legal Services Corporation-funded programs and AoA-funded projects and agencies at the State and local level. Under the aegis of this statement of understanding, as the agreement is entitled, the Corporation and AoA have worked cooperatively on a number of efforts to benefit the low-income elderly population. Recently, the two agencies extended an existing agreement for the utilization of Corporation employees by AoA to assist with the development of legal services activities authorized and funded under the Older Americans Act. These employees serve as the Corporation's liaison in the continuing implementation of the statement of understanding between the two agencies.

Finally, the Corporation entered into an agreement with the Administration on Aging, the U.S. Commission on Civil Rights, the Department of Health and Human Services' Office of Civil Rights, the Equal Employment Opportunity Commission, and the American Bar Association Commission on Legal Problems of the Elderly to establish a Task Force on Older Americans Civil Rights and Age Discrimination. The purpose of the agreement is to facilitate communication, coordination, and cooperation among the parties to reduce or eliminate negative social stereotyping of older people, to assure full protection under established civil rights laws, to reduce or eliminate barriers which deny access to services or benefits, and to promote an individual's right to pursue economic and social independence and self-sufficiency.

I hope this information will be helpful to you. If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,

DAN J. BRADLEY, *President.*

Enclosure.

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SUMMARY OF THE STUDY ON THE SPECIAL DIFFICULTIES OF ACCESS AND SPECIAL UNMET LEGAL PROBLEMS OF THE ELDERLY AND HANDICAPPED

I. INTRODUCTION

The findings of the study conducted by the Legal Services Corporation (LSC) on the special difficulties of access and special unmet legal problems of the elderly and handicapped are reported in this executive summary. The policy decisions made and actions which LSC will take to implement the study findings in this summary also are presented. The full study details the study findings and describes and analyzes the current efforts of legal services programs in representing the elderly and the handicapped.

Section 1007(h) of the Legal Services Corporation Act required LSC to study the special difficulties of access and special unmet legal problems of veterans, Native Americans, migrants and seasonal farmworkers, people with limited English-speaking abilities, and persons who reside in sparsely populated areas.[1] Section 1007(h) did not mention the elderly and the handicapped. However, the elderly and handicapped are specifically mentioned in section 1007(a)(2) of the Legal Services Corporation Act. Because of this express statement of congressional concern for these groups and the existence of the research team to meet the specific section 1007(h) mandate, LSC broadened the study to include them.

Research Questions

The study of the elderly and the handicapped used the same research questions as the study of the section 1007(h) groups, that is: (a) Whether or not the elderly and handicapped have special difficulties of access to legal services; (b) whether or not the elderly and handicapped have special legal problems which are unmet; and (c) what should LSC do about the special access difficulties or special legal problems it finds. This study also examined the needs of the elderly and handicapped in relation to the total of resources providing civil legal assistance for them. The availability and intended uses of non-LSC resources are major areas of inquiry for the elderly and handicapped because the resources are substantial and little has been written about them in the past.

Access

The term "access" is vague. In general, this study opts for a broad use of the term, encompassing not only physical access—that is, the ability of an eligible person to reach and receive some service from a legal services program—but also the actual nature and extent of service, including the extent to which the provider meets the special needs of the client. There are two main reasons for adopting this broad definition. First, it is important as a matter of study methodology to start with the broadest notion of access possible, so that in gathering information all factors relevant to the perceptions of access by interested persons and legal services programs are considered. Second, even if a narrow view of access were adopted, it would be necessary to relate difficulties of access to the end product—the representation provided or its effect—and, thus, all factors relating to that end product must be examined.

At the outset of this study, seven major possible access barriers were hypothesized for the section 1007(h) study. This was done both to target information collection and to provide a context for analysis. The most obvious access barrier—true to some extent for all groups—is no available legal services.

A related (second) access barrier is inability to reach program offices because of physical distance, lack of transportation and the like.

A third access barrier is the inability to obtain service on a particular legal problem after a potentially eligible client reaches a legal services office because of program inability or unwillingness to provide representation. A number of factors can cause this barrier to emerge for any group: Local priority determinations, caseload pressures or the like. The study sought to determine the extent of this barrier by questioning various relevant organizations (e.g., does the local program serve members of the group?) and by examining local program priorities and policies.

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[1] Special Legal Problems and Problems of Access to Legal Services of Veterans, Migrant and Seasonal Farmworkers, Native Americans, People with Limited English-Speaking Abilities, Individuals in Sparsely Populated Areas, Legal Services Corporation, June 1979.

The fourth access barrier is lack of knowledge—that is, potential clients do not understand either that there is a legal services program available to serve them or that it can be helpful on a particular problem. The study explored the extent to which programs engage in activities, such as publicity, outreach, community education, and training of lay advocates, which impact on client awareness.

A fifth barrier concerns sources of information or referral which direct clients elsewhere irrespective of the desirability and potential effectiveness of assistance from a legal services program.

The sixth access barrier is due to language, ethnicity, and culture. Potential clients may not seek services from a program unless, through its staff or otherwise, there is some ethnic or cultural identification that makes the individual feel a sympathetic audience is available.

A seventh access barrier relates to expertise and, at least inferentially, to quality. Access may exist but be ineffective or of limited use for any particular group if a program is unprepared to handle the type of problem presented. This can occur because a program is presented with a problem only infrequently, because the problem is particularly complex, because resolution requires substantial resources, because the staff is inadequately trained or the like. Because this study focuses on the special problems of particular groups and not the problems of all poor persons, it is not surprising that this barrier was often found for parts of each group on some problems.

In addition to the seven access barriers originally hypothesized for the five section 1007(h) groups, eight barriers were added for the elderly and handicapped for purposes of information collection. These eight represent both a broadening and narrowing of the original list. A few are different from the original list; most, however, address a specific aspect of general statement.

(1) *Stigma of charity.*—This barrier is often asserted for the elderly. The theory is that the elderly will not use services having a "means" test because of association with charity and/or will not use the services of a provider who serves primarily poor persons.

(2) *Staff discrimination and/or disinterest.*—This barrier would exist, for example, if staff believed the legal problems of elderly and handicapped persons are insignificant or unimportant and refused to serve them. It might arise from a disinterest in or dislike for serving the elderly and handicapped whatever their legal problem, because of frustration dealing with clients who don't communicate well.

(3) *Eligible individuals are unaggressive and won't take risks.*—Adding this concept and labeling it as a possible barrier probably represents the outer limits of the concept of "access" since client choice and control is a basic tenet of legal services. However, a client may forego rights or refuse to pursue them to the point where legal services, theoretically available, are of little value. When lack of aggressiveness reaches this level, it is appropriate to regard it as an access barrier.

(4) *Service is in dangerous neighborhoods.*—It is often asserted with respect to urban areas that elderly persons—and to a lesser extent handicapped persons—will not go to service providers in areas where there is a real fear for personal security. This could be viewed as a corollary of (1) above since location in dangerous neighborhoods is commonly a basic method of service delivery to he poor.

(5) *Communications is difficult or impossible.*—This barrier might particularly be applicable to certain subclasses of the handicapped—the deaf, the blind, the severely mentally disabled. It is, however, also asserted about the elderly at least to the point of suggesting that particular patience and understanding is a prerequisite to effective communication.

(6) *The potential client can speak only through surrogates who won't use legal services.*—The surrogate here could be a parent of a mentally retarded child or a guardian of an older person. The interests of the surrogate may be different from those of the handicapped individual and the surrogate may even be the source of the legal problem.

(7) *The facilities of the legal services provider are structurally inaccessible.*—This barrier is primarily applicable to the physically handicapped and relates o the structure of facilities rather than their location.

(8) *The potential clients are institutionalized and cannot seek services.*—Age nd disability are, of course, two major reasons for institutionalization and thus t is appropriate to raise this access barrier here.

The study mandate requires examination of access difficulties only if they are "special." Throughout the study, "special" has been used interchangeably with "status related," so that the inquiry covers access difficulties directly related to the characteristics used to define the group. "Special" has not been defined to mean "unique." Use of a definition that narrow would eliminate almost all access barriers for the groups in the study.

The list of possible barriers was developed only as a starting point. It served to direct the inquiry and provide some categorization for initial analysis. As the full report details, however, national level conclusions premised on precise characterizations of access barriers are all but impossible where substantial variation in circumstances, attitudes, and needs as well as in services exists.

Unmet Special Legal Problems

As with the study of the section 1007(h) groups, this study used a broad notion of what is an "unmet special legal problem." Thus, the inquiry was not narrowed by a limited view of what legal problems are "special" or of what problems are "legal." Nor were certain problems omitted because of some belief they are not "unmet."

Using a broad starting point delays but does not avoid the narrowing process. The elderly and handicapped are large and diverse groups. Analysis of all their possible legal problems is well beyond the resources of a study of this nature. There was an attempt from the beginning to concentrate on legal problem areas that seem to have the highest incidence and are most related to group "status." Thus, the study looks least at problems that are shared by all poor but are otherwise unrelated or only loosely related to elderly or handicapped status. It also looks least at problem areas that appear to affect only a few persons.

There is a philosophical choice behind these targeting decisions. The purpose of the study is not to list legal problems or to analyze them like a legal text. Rather, the purpose is to determine whether there is unmet need with respect to special legal problems. This purpose can be realized best by looking at the most visible, important and pervasive of the special legal problems on the assumption that legal services should be most responsive to these problems, and thus the problem can serve as a bellwether of the overall legal services effort.

Categorization

During the course of the study, it became apparent that one subclass of the elderly and the handicapped—those who are institutionalized—were so related that the fact of institutionalization is more important to both access and to the presence of legal problems than either age or disability. For this reason, the institutionalized have been separated out and are discussed separately. Specific findings and recommendations covering solely the institutionalized are included.

The special treatment of the institutionalized is actually one aspect of a larger overlap between the elderly and the handicapped. A substantial part of the handicapped are elderly; a substantial part of the elderly are handicapped. This means that any findings or conclusions arrived at with respect to persons under one label (either elderly or handicapped) are applicable to some extent under the other label.

While the overlap between elderly and handicapped is substantial, it generally was not explored in the study. Many of the persons interviewed in the study and many who served on study advisory groups recognized the connection, but no one suggested any particular policy directions that should come from it. In fact, these persons usually considered only one label relevant and suggested policies around that one label. Thus, someone might suggest certain actions for an elderly blind person because that person was elderly or because that person was blind but not because the person was elderly and blind. The study generally adopts this approach.

II. NONINSTITUTIONALIZED ELDERLY

A. Background

For purposes of this study, an eligible elderly person is a person who has an income equal to or less than 125 percent of the poverty level and who is 60 years or older. Because of limitations on data availability on important issues, the study was occasionally required to use data based on an age cutoff of 65 years or data based on all elderly persons irrespective of income. In those instances, the data is being used as if it related to the definition of elderly otherwise used in the study, and the error involved in the substitution has to be considered in looking at any findings or conclusions based on such data.

According to the "Survey of Income and Education" (SIE) conducted by the Census Bureau in 1976, 16.5 percent of the poor persons in the United States are age 60 or older. Although there is a higher incidence of poverty among the elderly than among the nonelderly, there has been a steady decrease in poverty among the elderly since poverty statistics were first compiled.[2] Today, the elderly are a smaller share of the poverty population than the SIE reflects.

The elderly have always been part of legal services caseloads although special targeting on their needs has historically not been the rule. The Office of Economic Opportunity (OEO) funded a number of model projects for legal services to the elderly and in 1972, established the National Senior Citizens Law Center to serve as a national support center for legal services to the elderly delivered by local programs.

Overall there was little special activity for the elderly until the passage of the title III of the Older Americans Act (OAA) in 1973. Legal services activities for the elderly funded under the OAA have steadily grown since 1973. In 1978, each area aging agency (AAA—the local distribution point for OAA funds) was required by amendments to the Older Americans Act to devote "some funds" to legal services. Recently, the Administration on Aging (AoA) has promulgated regulations defining standards for legal services providers. Additionally, AoA has created a number of biregional centers to provide technical assistance, support, and training to assist advocacy efforts of AAA's State offices on aging and legal services providers.

Although since 1973 AoA has become the major source of special legal services for the elderly, the Legal Services Corporation funds legal services programs covering almost all of the country and serving the elderly poor as part of service to the overall poverty population. To facilitate some coordination of activities at the national level, LSC and AoA have entered into a cooperation agreement whereby two LSC staff persons are stationed at AoA and work on legal services.

The involvement of two major funding sources makes the situation at the local level difficult to describe. Roughly 70 percent of the AAA's were providing "some funds" to legal services in mid-1979. In many instances, however, the funds were going to only a part of the AAA service area. At that time, approximately 80 percent of the counties in the country were covered by an LSC-funded program.

The most common arrangement around the country—applicable to 60 percent of the AAA's which fund legal services—is that the AAA provides funding to the LSC-funded legal services program which then establishes a special unit for the elderly using primarily AAA and LSC funds. In the remaining 40 percent of the areas, there is great diversity of approach. Often, a separate legal services program is established solely to serve the elderly. In other cases, law schools, bar associations, AAA staff, and other social programs have been funded.

Because LSC will not complete full geographic coverage until the end of 1980 and because not all AAA's fund legal services, there are a few areas of the country where the elderly have no legal services available. In many areas, they have available only the services provided to elderly persons by the LSC-funded program.

While 70 percent of the AAA's provide some funds for legal services, the amount is generally small in relation to the population to be served. This is especially true if the population to be served includes nonpoor elderly.

One other point about local legal services to the elderly is important. The term "legal services" is sufficiently broad to encompass many advocacy, counseling, and educational activities. Especially among AAA-funded programs not connected with an LSC program, the type of service delivered to the elderly and, as a result the staffing, are atypical for legal services generally. Thus, a program for the elderly might provide primarily legal education or social worker counseling with little lawyer involvement or advocacy.

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[2] In 1959, the Census Bureau reported that 35.2 percent of the elderly were poor. In 1978, the Bureau found that 14 percent of the elderly were poor. See U.S. Bureau of Census, Current Population Report: Money Income and Poverty Status of Families and Persons in the United States: 1978 at 28 (November, 1979).

B. Special Difficulties of Access to Legal Services

There are two ways to look at access to legal services for the elderly: (1) Whether the elderly overall have sufficient access to legal services; (2) whether hypothesized special access barriers for the elderly are present. Data on 48 staff programs from the Delivery Systems Study (DSS)[3] were examined to address the overall access issue. The examination covered the extent to which elderly clients appear in program caseloads in comparison with the percentage of poor persons who are elderly. The hypothesis behind this examination was that numerical underinclusion—a percentage of program clients who are elderly which is less than the percentage of poor persons in the area who are elderly—could be equated with access insufficiency.

The DSS data did not show significant underinclusion of the elderly in program caseloads overall. Further, the data showed the methodological weakness of looking at numerical underinclusion in caseloads as a measure of anything, including access insufficiency. From the data, it is apparent that the percentage of clients who are elderly in any LSC program is determined primarily by whether the program handles case types that are de facto age targeted either at younger persons—e.g., juvenile, AFDC, domestic relations, employment—or at older persons—e.g., wills, guardianship, nursing home problems. The decision of whether or not to handle such cases to any particular extent involves considerations beyond numerical inclusion of elderly persons or those of any other age.

From the data and site visits, however, it is apparent that some programs serve very few elderly clients. Depending on the reason for this limited service, these programs may be discriminating based on age. Since HEW has recently issued model age discrimination regulations and LSC can, but is not required to, issue its own age discrimination regulations, this finding suggests that some age discrimination standard must be created. Therefore, as a result of the finding that a small minority of programs serve very few elderly clients:

> As part of a general effort to define the civil rights responsibilities of programs, LSC will enact a regulation to enforce the Age Discrimination Act. Further, LSC will inform all programs of their obligations under the Age Discrimination Act.

The second aspect of access—where hypothesized special access barriers for the elderly exist and are unmet—is more difficult to address from a national perspective because of the tremendous variation in local circumstances and responses. Generally, where there is AoA-funded legal services for the elderly and this funding results in a special unit or program for the elderly, the major special access barriers are addressed. In fact, most of the major access barriers of the elderly covered in this study are special in degree only and it is common in a local area for the barriers to be addressed for the elderly but not for others.

There are exceptions as well as solutions that appear to raise their own problems. Programs and special units for the elderly often find the elderly do not want to use legal services or assert rights because of an unwillingness to take risks or a belief that problems will take care of themselves. This attribute, to the extent it exists, may be generational and may disappear or decline as time goes by. There is, however, no definitive way to deal with it.

While there is some feeling that even poor elderly will refuse to seek services governed by a "means test," the special units and programs appear able to overcome any problems by a careful creation of an image that the program or unit is only for the elderly and separate from any general program for the poor of which it might be a part. At the same time, most of the programs units use some form of means test.

The elimination of means testing in services to the elderly can only cause a reduction in service to the poor elderly irrespective of the method used to target services to those with greatest social and economic need. Thus, absence of a means test will itself raise access difficulties because the poorest, least assertive and least vocal segment of the elderly will be required to be more aggressive about seeking service and asserting rights. It will also very likely exacerbate a problem of the underinclusion of minorities in some areas since minority elderly are more likely to be poor than majority elderly.

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[3] The Delivery Systems Study was undertaken by LSC pursuant to section 1007(g) of the Legal Services Corporation Act. An initial report was issued in July 1977. A final report will be available in July 1980.

While staff in most LSC-funded programs appear willing and able to serve the elderly, there are some problems with program staffing and policies that bear on elderly service. Only a minority of LSC programs have any elderly staff and the number of these programs is small. Even in special units for the elderly, many programs do not have elderly staff. Since there is a belief that at least some elderly staff are likely to improve representation of the elderly and producing job opportunities for elderly persons is itself a desirable end:

> LSC will inform all programs of their obligations under the Age Discrimination in Employment Act.

There is a widespread belief that the extent of local services to the elderly by LSC programs has been determined by priority setting and in that process, service to the elderly has somehow been reduced in relation to others. From the site visits in this study, it appears that at least half the programs have no formal priorities that govern service delivery, though most are somewhere in a priority setting process. Further, among those that have priorities, it does not appear that they give more or less service to the elderly than those without priorities.

The main influence on consideration of the elderly in priority setting has been the availability to the program of non-LSC funding for services to the elderly or, alternatively, the availability of special services for the elderly from another program. There is a tendency to consider the non-LSC resources together with the money they "leverage"—either LSC or other—as the proper resource commitment to the elderly whether or not a program goes through a formal priority setting process.

Addressing the needs of the elderly in priority setting produces logical and practical difficulties because it mixes people characterized by age with issues or areas of legal problems that concern some poor people. Program staff almost invariably believe that only categorization by legal problem makes sense in priority setting, so they lump the elderly in with others to reach a delivery structure that would not separate clients by age. Advocates for the elderly (including staff serving them) take the position that mixing the elderly with others under legal problem headings is wholly inappropriate; they pursue a separatist structure irrespective of duplicate coverage of legal problems. There is no clear compromise except that caused by non-LSC resources supporting a special unit. Without non-LSC resources, program staff would generally not create a special unit for the elderly or specialize based on age division exclusively. Priority setting has little influence on the existence of special units or on specialization.

Although the result of priority setting for the elderly has been little or no change in the status quo, the process appears controversial because the results could theoretically dramatically change the nature of the program. In addition, there is a clear difference between promise and reality. The most obvious evidence of the latter point is the fact that the elderly and their advocates appear to be included in the process in virtually all programs and yet, the result produces little for the elderly beyond the status quo.

Based on these findings with respect to the elderly and other problems with priority setting that have emerged:

> The current process within the Office of Field Services, LSC to redesign LSC policies on program priorities and planning will seek to simplify the recommended process and emphasize results not procedure.

This discussion of specific, hypothesized access barriers is intended to cover specific weaknesses in current delivery that warrants action. Overall, the examination of the hypothesized barriers only reinforces the general view that access barriers for the elderly have been overcome in most areas.

C. Unmet Special Legal Problems

The study showed two types of special legal problems of the elderly: (1) Those that apply to all ages but may have an unequal impact on the elderly; and (2) those that are somehow unique to the elderly or different in kind. Another way to categorize the problems is in terms of the solution. Again, there are two major categories: (1) Problems resolvable primarily by assistance to individual elderly persons whether that assistance be representation, counseling, education or some other service; (2) problems resolvable primarily by rule or system change for the benefit of substantial numbers of persons whether through litigation, rulemaking advocacy, legislative advocacy or some other service. Consideration of both types of categorization are necessary to evaluate the extent to which the special legal problems of the elderly are unmet.

The following is a list of the most important special legal problems as derived from AAA's and senior citizens' organizations' questionnaire responses. The list is used primarily as a vehicle to understand the nature of the legal problems and categorize them. These problems might not be judged the most important in any particular local area. The problems are categorized in the terms outlined above.

(1) *Governmental income maintenance.*—The elderly share a number of income maintenance programs with others—primarily the disabled—so that the problems are not unique to the elderly although older age is usually an eligibility factor. Among the programs are supplemental security income (SSI), social security (title II, retirement benefits), railroad retirement benefits, and veterans' benefits. The programs and beneficiaries are generally lumped together so that actions to benefit one type of recipient is likely to benefit another.

Income maintenance programs of primary benefit to the elderly are generally run at the Federal level. While there is a need at the national level for advocacy affecting overall operation of programs, the primary need is for individual representation and assistance.

(2) *Housing.*—The housing problems of the elderly poor are similar to those of poor persons generally. However, there is a higher incidence of homeownership among the elderly than among all poor. Some public housing programs are partially targeted on the elderly, but the problems appear similar to those for all public or subsidized housing tenants.

Many of the housing problems are resolvable through individual representation, counseling, and education. Especially as to public and subsidized housing and housing-related consumer problems, there appears to be a real need for an institutional perspective and orientation.

(3) *Alternatives to institutionalization.*—While this area generally applies to any group which is institutionalized, the unique situation of the elderly with respect to nursing homes, mental hospitals, and other institutions means the problems and solutions are different in kind for the elderly. While there is room for individual counseling and representation to obtain what benefits are possible with existing programs and resources, the real need is for systems change that creates realistic alternatives to institutionalization. This need, in turn, demands legislative, administrative and litigation advocacy on a broad-based level.

(4) *Wills and estate planning.*—While this might be seen as a legal need to be satisfied primarily when a person is younger, the reality is that it is not met or even perceived in most cases until a person becomes elderly. This reality and the common need or desire to change testamentary arrangements makes it an area special for the elderly. While a limited amount of systems advocacy may be necessary to create effective testamentary disposition laws, the need is primarily for individual counseling and document preparation.

(5) *Medicaid/medicare.*—These health care financing programs are related to income maintenance programs and many of the same considerations apply. However, medicaid is administered by the States and issues of consistency of State policies with Federal requirements are common. Moreover, medicare is an unexplored area. As a result, there may be a greater need than in income maintenance programs for more systematic advocacy aimed at program operation—including legislative, administrative, and judicial.

(6) *Guardian/protective services.*—Older age, with associated infirmities, is one reason for protective services and guardianship. In most States it is the most common reason. In this area the need is primarily for individual counseling and representation of the involved elderly person and relatives and friends. There is a tremendous need to modernize guardianship and protective services laws; legislative advocacy is desirable for all elderly. Improving the practices and procedures by which guardianships are obtained may also be a serious issue in many jurisdictions.

(7) *Utilities.*—Problems of utility price and supply are shared by all poor persons, although the impact on the elderly of service interruption or rate increases is the most severe. While there is some need for assistance with individual disconnection or deposit issues, the real need is for legal advocacy in the regulatory agencies to insure fair distribution policies and to minimize price. These are generally very large proceedings involving both tremendous time commitments and the use of various professionals, including economists and engineers.

(8) *Other health problems and insurance.*—These problems are related because insurance for special problems of the elderly invariably covers health care. The insurance issues—generally involving the relation of private insurance to medicare or medicaid (so called "medigap" insurance)—are largely unique to the elderly. The solution may involve both client education and administrative (rulemaking) advocacy. Otherwise, the health problems not covered above (medicaid/medicare, alternatives to institutionalization) appear to require group advocacy.

The degree to which these legal problems are met varies from local area to local area. Two findings are possible at the national level:

(1) Except for estate planning, special legal problems of the elderly are most likely to be addressed and met if they are shared with other poor persons;

(2) Special legal problems of the elderly are most likely to be met if the solution involves individual education, counseling and representation.

The first finding is self-evident from the nature of programs delivering legal services at the local level. To the extent problems are shared by a significant segment of the poor, it is likely there are specialist staff addressing the problem. Particularly where the need is for system or rule changes, actions for the non-elderly do not directly benefit elderly persons with the same problem. While this is true for almost all problems discussed above, the use of special units for the elderly not connected with substantive-area specialists considering similar problems results in duplication. Duplicated service reduces the likelihood that problems will be addressed only if they are shared.

The second finding is consistent with the nature of programs and units delivering legal services to the elderly. The high emphasis on physical access and education and the accompanying heavy dependence on nonprofessional advocates and nonlawyer professionals makes it difficult for many programs and units to engage in litigation, legislative, or administrative policy advocacy.

Thus, the issues discussed above that require more than individual representation are generally not sufficiently addressed, and there is clear unmet need. Even those issues that necessitate only individual representation may be unaddressed if litigation is required. Where there are special units or programs, the lawyer staff—if there is any—is often tied up in supervising nonprofessional staff and in outreach and is not available for litigation. About half the special units visited during the site visits were engaged in virtually no litigation.

In addition to the special legal problems discussed above, there are others directly related to older age. They include age discrimination, particularly in employment, and pension rights. The fact that these problems were not raised by AAA's or senior citizens' organizations probably reflects a lack of understanding that rights exist and can be enforced. This is another indication that special legal problems are often insufficiently addressed.

To stimulate and increase work in particular areas two methods have been used in the past: (a) Training, and (b) support. These are related activities and often come from the same source, e.g., a support center.

Although the National Senior Citizens Law Center provides support assistance on most special legal problems of the elderly and other support centers (for example, Center on Social Welfare Policy and Law and National Health Law Program) cover substantive areas of particular concern to the elderly, no manuals on law relating to the elderly have been developed by LSC. Similarly, there has been no national training in most of the special legal problem areas in a number of years. The training and manuals available under the auspices of AoA or within the aging network are too basic to be of assistance in motivating programs to address unmet special legal problems.

As a result of the above findings on coverage of unmet special legal problems, the following actions will be taken:

To the extent funding is available for substantive training and development of manuals, LSC will develop manuals and training on the special legal problems of the elderly (particularly, including issues not covered in previous training). The training will be open and the manuals available to clients and staff in both special elderly units and other program units. LSC will continue consistent with its allocation process to provide funds to existing support centers to assure that adequate support and advocacy are undertaken on age-targeted issues, such as age discrimination, pensions, medicare and long-term care. Other actions relating to support and training are discussed below under LSC/AoA cooperation.

D. Conclusion Relating to Both Access and Special Legal Problems

There is an inverse relationship between a program's ability to meet all access difficulties and simultaneously address special legal problems, particularly those requiring extensive resource commitment to litigation, legislative, or administrative advocacy. The current special units created with a mixture of AoA and other (LSC included) funding generally give highest priority to access, often to the exclusion of many special legal problems of the elderly.

While the special units for the elderly seem effective in achieving access, the gaps in services provided and problems addressed suggest caution in endorsing the approach without reservation. Even if the needs of the non-elderly were not considered, it may be that delivery systems structured along substantive speciality lines without age divisions would produce a better balance of substantive expertise and access to service. Thus, this study does not conclude that LSC should insist on any specific approach by local programs.

To a great extent, the effectiveness of service to the elderly is dependent upon local cooperation and coordination between LSC and AoA resources and national level coordination.

There appears to be sufficient coordination and reasonably fair allocation of responsibilities at the local level. At least within LSC programs, AoA funding through AAA's leverage other resources to the overall benefit of the elderly. The mix of resources is locally bargained in a way that appears in many areas to achieve sufficient resources for the elderly within limits of available funds. Of course, the severe limitations on resources available both from AAA's and legal services programs makes the total resource commitment for legal services to the elderly inadequate in many areas.

While cooperation may be the norm, there are many instances of lack of cooperation. Often this lack of cooperation can be traced to philosophical differences, although disagreements over issues like the means test have occurred. Overall, a thorough discussion and explanation of the nature, role and expected result of legal services would probably facilitate cooperation.

National cooperation is largely based on an agreement for coordination between LSC and AoA and the placement of LSC staff at AoA. It is particularly important that both LSC and AoA create an atmosphere whereby aggressive, quality advocacy will result.

The one place where there needs to be more effort is national support. AoA has recently established a new biregional support center structure although National Senior Citizens Law Center (NSCLU) is funded to undertake some national training and support. The national contract to NSCLC will terminate shortly and may not be renewed. AoA's biregional centers have primarily a training role. However, training efforts have been aimed at delivery issues and not at creating expertise on the special legal problems of the elderly. Further, because training policy is controlled by State aging offices, the training may be of only limited benefit to legal services providers. Meanwhile, assistance on advocacy, including help on specific cases, legislative and administrative projects, is a secondary part of the mission of the AoA centers.

The result of the AoA biregional centers' orientation appears far short of developing expertise in aggressive advocacy to respond to special legal problems of the elderly. LSC can fill some of this gap but the overall result still appears to be a misplaced emphasis on access.

Based on the above findings, the following actions are appropriate:

> LSC will work with the Administration on Aging to help develop an effective legal services network and to encourage local area aging agencies to support aggressive, quality legal services for the elderly. LSC will seek to establish with the Administration on Aging a national support structure that will assure that LSC grantees receiving AoA funds, as well as other AoA grantees providing legal services, have access to effective training, technical assistance, clearinghouse services, manuals, advice and assistance, cocounseling, coordination, and communication on issues affecting the elderly, and to gain AoA assistance in funding a national support structure that will provide advocacy (including legislative and administrative representation) on a national level on elderly issues.

III. NONINSTITUTIONALIZED HANDICAPPED

A. Background

The term "handicapped" can be given many definitions based on the nature, severity, and duration of the disabling condition. For purposes of this study, the definition of handicapped used is that of the Rehabilitation Act of 1973, as amended, and regulations implementing the act. The definition of "handicapped person" is:

> [A]ny person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.

45 CFR § 84.3(j)(1). Note this definition includes the terms "physical or mental impairment" and "major life activities" which, in turn, are defined. It is sufficient to say the definition of "physical or mental impairment" is very broad. The definition of "major life activities" is:

> [F]unctions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

45 CFR § 84.3(j)(2)(ii).

In this summary as well as in the study report, the term disabled is often used. It is intended to be a synonym for the handicapped and not to have the particular meanings ascribed to it in the Social Security Act and elsewhere.

For many purposes the section 504 definition is too broad. For example, it imposes no permanency requirement so that a person with a temporary illness may be handicapped during its duration. Similarly, persons may have impairments that "substantially limit" a major life activity but the impairment may raise no legal services access barriers either because the impairment is of insufficient severity or because it relates to a life activity that is irrelevant to legal services access.

It is important to emphasize, however, that any overbreadth in the section 504 definition for purposes of the study is limited to only some issues. Any person within the scope of protection of section 504 may have enforcement of rights under the section as a special legal problem. An individual suffering from "black lung" may have no difficulty of access to legal services but still have a legal problem arising out of difficulty in obtaining appropriate black lung benefits. In general, this study looks at access questions in the context of the more severely handicapped persons and special legal problems in the context of a broad definition of handicapped persons.

Adoption of the relatively broad definition of the Rehabilitation Act necessitates use of subcategories in many instances. For example, distinctions are often made based on whether a person is physically or mentally disabled. Distinctions are also drawn to distinguish a person who is severely handicapped from one who is less than severely handicapped. While some narrowing of the meaning of these terms is possible, any definition ultimately has to vary based on how the terms are used. For example, with respect to a mentally disabled person, the term "severely handicapped" might be used to indicate that client decisionmaking and effective communication between attorney and client is impossible. When describing a physically disabled person, the term might be used to indicate a person who would be wholly unable to enter a building with an architectural barrier.

Because the category "handicapped" has emerged only recently for use in social programming, there is no definitive enumeration of the number of handicapped persons in the United States or the number of poor handicapped. Estimates of the number of handicapped persons in the country vary widely with the upper ranges exceeding 70 million persons. Because handicapping conditions affect the ability to earn income, it is fair to assume there is a higher incidence of poverty among handicapped persons and, thus, a higher percentage poor than nonpoor are handicapped. It is not outside the range of possibility that 50 percent or more of the poor persons in the United States are handicapped.

The following are "order of magnitude" estimates of significant parts of the handicapped population by handicapping condition.

a. Visually impaired	
Severe (can't read with lenses)	1,391,000
Not severe	10,240,000
b. Hearing impaired:	
Deaf	2,200,000
Bilateral loss	5,800,000
Single ear loss	8,200,000
c. Speech impaired	1,995,000
d. Physical disabilities:	
Absence of major extremity	358,000
Paralysis of part of body	1,532,000
Orthopedic disorder (w/o paralysis)	9,365,000
e. Mentally retarded	4,400,000
f. Epilepsy	2,135,000
g. Cerebral palsy	760,000
h. Multiple sclerosis	300,000
i. Muscular dystrophy	200,000
j. Mental illness	32,000,000

Traditionally, there has been no special emphasis on the handicapped in legal services programs. In part, this is because the categorization and legal issues and rights based on categorization are relatively new. Also, this is because (as described below), the noninstitutionalized handicapped have been an integral part of program caseloads so that any kind of special emphasis appeared unnecessary.

As new legislation created rights based on handicapped status, there has been some experimentation both locally and nationally in meeting special needs of the handicapped. A few programs have created specialists or special units to serve the handicapped, usually on specific legal problems. LSC has specially funded Community Action for Legal Services (CALS) to operate a special support unit (called the Handicapped Persons Support Unit) to focus on problems of the handicapped, cocounsel cases and train CALS staff.

Many of the major legal problem areas are covered in the national support structure. For example, a substantial percentage of the time of the Center for Law and Education is used in providing support on issues related to the Education of All Handicapped Children Act and education rights of the handicapped.

Probably most of the special efforts for the handicapped or significant subcategories of the handicapped has come from non-LSC resources. The Development Disabilities Protection and Advocacy (P&A) systems, funded in each State by HEW, have in most States provided legal representation to the developmentally disabled. (Historically, this has been the mentally retarded and those with epilepsy, autism, or cerebral palsy, although the definition is now expanded.) Because the P&A systems receive very little funding, it is not likely they approach meeting completely the needs of the developmentally disabled anywhere.

In some States or local areas, legal services to the noninstitutionalized mentally disabled has grown out from commitment representation (treated under the institutionalized, infra) or from representation of institutionalized mentally disabled. These efforts are sporadic at best.

A number of private organizations have provided legal services to the handicapped. The American Bar Association Commission on the Mentally Disabled used foundation money to fund a number of bar associations to deliver services to the mentally disabled. Some of these projects emphasized the noninstitutionalized mentally ill or developmentally disabled.

Some of the advocacy organizations for subclasses of the handicapped provide limited legal services, usually from Washington staff attorneys or funding local attorneys. Some of the organizations—for example, the Association for Retarded Citizens—have local chapters large enough to afford an attorney and/or lay advocates at least part time. Some law schools have emphasized the handicapped.

The situation with respect to national and regional support is similar. HEW funded the National Center for Law and the Handicapped to provide national support primarily on issues of concern to the physically handicapped and developmentally disabled. It also funded regional projects to advocate for the developmentally disabled and support the P&A systems.

The National Center for Law and the Deaf and the Mental Health Law Project have been supported generally by private funding to provide national support, legislative advocacy, national litigation representation, training, etc. in the rights of the deaf and hearing impaired and rights of the mentally ill or allegedly mentally ill. Other national organizations to some degree offer national advocacy support from Washington.

As is obvious from the foregoing discussion, most of the special efforts funded outside of LSC cover only the mentally disabled or part of this group. Almost no public resources go to special legal services efforts for any physically handicapped people.

B. Special Access Difficulties

As with the elderly, it is appropriate to look at the access difficulties of the handicapped from two perspectives: (a) Overall to determine whether or not programs fairly serve the handicapped; (b) in relation to hypothesized access barriers. The following discussion gives an overview from both perspectives.

It is difficult to determine the overall level of LSC program service to the handicapped because of lack of data. There is no way to ascertain the incidence of handicapped persons in the service area of any program. Even if there were, it is unlikely that any programs have kept data on whether or not clients are handicapped.

In the absence of data on services to the handicapped, this study must rely on the perceptions of local staff, clients and advocates as well as the information available on types of cases handled by programs.

From this information, it appears that the handicapped are fairly served overall. This is because many programs have emphasized income maintenance and staff have handled many cases in this area for the handicapped. The overview has to be tempered, however, with an understanding of the existence of some significant gaps. Thus, it does not appear that most programs serve the severely handicapped to any great degree. This lack of service is no doubt the result of specific access barriers discussed below.

The study covered a number of specific access barriers to gauge the extent to which they exist and the extent to which programs seek to address them. The following is a discussion of the most significant access barriers.

The access barriers raised first with respect to the handicapped relate to the effect of their disability or ability to take advantage of program services. Included are the effects of architectural barriers and the absence of special efforts to communicate with the sight, hearing or speech impaired. The problem is often stated as one of "facility accessibility".

To a great extent, the issue of "facility accessibility" is simply an issue of compliance with section 504 of the Rehabilitation Act and regulations issued pursuant to section 504. The theory is that facilities are inaccessible to the handicapped if they do not comply with this law and regulations.

Because of the technical nature of the requirements of the facilities accessibility regulations, it is impossible to cover every aspect of it in this study. A survey of 99 sample programs was done in 1979 covering four areas of program facilities and operation: (a) Reception area; (b) confidential interview space; (c) rest rooms; and (d) availability of deaf communications. In addition, programs were asked whether or not alternative accessible sites were available to serve handicapped clients when the local office is to some extent inaccessible, and whether or not arrangements have been made with sign language interpreters to serve the deaf.

The survey showed that the availability of accessible facilities depends most on the kind of service or type of facility involved. Thus, over half the programs (53 out of 99) reported that all their interview areas are accessible to the handicapped. Somewhat less than half (42 out of 99) reported all reception areas in the program are accessible to the handicapped. Most of the remaining programs (36 for interview areas, 48 for reception areas) reported some but not all facilities accessible to the handicapped.

There is a greater problem with respect to deaf communications and rest rooms. Only 16 programs reported that all rest rooms are accessible (33 reported some rest rooms are accessible). Only one program reported that it had deaf communications equipment in all offices (one other said it had such equipment in less than all its offices). Thirty-four reported having made arrangements for deaf interpreters at some time.

Compliance with section 504 does not always require all facilities be accessible as long as the program overall is accessible. Often compliance can be achieved through use of alternative accessible interview and service sites. The sample programs reported using alternatives for 47 percent of the facilities wholly or partially inaccessible (excluding whether or not they have deaf communications equipment). More often than not (68 percent of the programs) the alternative sites are publicized.

The foregoing data was gathered before LSC issued a regulation covering, inter alia, facilities accessibility requirements. See 45 C.F.R. Part 1624 (effective October 25, 1979). Both because of the regulation and because complete facilities accessibility is usually achieved over time, the data understates current LSC program facilities accessibility.

Even if programs are significantly more accessible than the data shows, there clearly needs to be improvement. Facilities inaccessibility is probably the major reason why there is a gap in service to the severely handicapped. This is particularly true with respect to the sensory impaired.

The weakness in accessibility for the sensory impaired probably has not been significantly alleviated by LSC's regulation. The regulation has an auxiliary aids requirement but it is so vague that programs cannot determine their compliance responsibility. Therefore:

> LSC will clarify the auxiliary aids requirement contained in its section 504 regulations to provide more specificity for the guidance of programs.

One way to achieve better facilities accessibility is through education of programs on what are often highly technical requirements. Accordingly:

> LSC will develop and disseminate a technical assistance manual on section 504 compliance by June 1, 1980.

Another way to improve facilities accessibility is through direct assistance, encouragement, and monitoring from the regional offices, the part of LSC closest to programs. Accordingly:

> Following the development of the technical assistance manual, LSC will train one staff person in each regional office to disseminate information to programs, to encourage local compliance with section 504 and give technical assistance on request, and
>
> As currently planned, the monitoring process will cover compliance with section 504. One person who is part of the monitoring process should be sufficiently familiar with section 504 requirements to determine program compliance.

Although LSC may not have a legal requirement to make its own facilities accessible, the formulation of policy covering the handicapped may require full participation of handicapped persons which is possible only if the facilities involved are accessible. Further, by making its facilities accessible, LSC sets an example for local programs. Accordingly:

> LSC will as soon as possible make its Washington facilities and activities fully accessible to the handicapped including the purchase of a TTY machine and the dissemination of information in such a way as to reach those with sight or hearing disabilities. Each of the regional facilities and activities will be evaluated to determine the extent to which handicapped persons may be affected and the extent to which they are accessible. To the extent necessary, regional facilities and activities will be made accessible.

While inaccessible facilities may present the foremost access barrier for the handicapped, they are only a part of a larger problem of immobility, at least for the physically handicapped. Thus, an eligible person may know of services and be able to use them but is unable to reach them. More likely, the handicapped person with limited mobility is unaware of legal services or how to use them because he/she couldn't reach such services.

A few programs have overcome this barrier by participating in transportation programs. Some programs could assist the clients in using available transportation programs. Most programs were willing to make home visits but never publicized this policy.

The best solution to the access problems appears to be outreach to the various groups and organizations that are interested in particular subclasses of the handicapped. The outreach is not generally designed for case intake at special facilities but instead to develop referrals from persons who are in contact with the handicapped, know how to handle mobility problems and are aware of the services of the program. Publicity and education through such referral sources is probably the most effective way to alleviate physical access problems while making potential clients aware of the presence and role of legal services.

Based on this finding:

> In order to encourage programs to engage in outreach to handicapped advocacy groups and to provide education, publicity, attendance at meetings and increased representation, the regional office person trained on § 504 compliance will also be knowledgeable about service delivery structures and policies that are effective and responsible in serving the handicapped and will be prepared to give technical assistance in this area.

Note that this action, while first addressed here, meets other access and special legal problem needs discussed infra.

A third access barrier of the handicapped may result from the policies, staffing and attitudes in programs. The issues here are similar to those raised for the elderly. Sometimes programs are perceived to give low priority to the handicapped. Further, staff are often seen as incapable or unwilling to deal with some handicapped persons, particularly the mentally disabled.

The relation between program priorities and service to the handicapped is almost identical to their relationship with service to the elderly. Similarly, all the findings made with respect to the elderly apply here with two exceptions. The first exception is the effect of non-LSC resources. Because such resources are less available for the handicapped than for the elderly, they are not such a dominant factor in determining what programs do for the handicapped. Second, there have been programs that have used LSC funds to create special units or staff for the handicapped. However, these units or staff actually cover certain special legal problems—like enforcing section 504—rather than serving the handicapped generally. Thus, they are aimed primarily at addressing special legal problems and not at overcoming access barriers. Despite these differences, the overall conclusions with respect to the elderly are equally applicable here.

Staff attitudes and ability to serve the handicapped obviously vary markedly. While staff unwillingness or inability to deal with mentally handicapped clients was seen as a problem for a few clients in a few programs, the problem does not necessitate special treatment for the mentally disabled. Developments in defining clearly the attorney's role in representing a mentally disabled client will be helpful; an explicit definition would give guidance to the attorney and hopefully engender an effective attorney/client relationship.

There is a very strong perception that use of handicapped staff will improve the client's view of program responsiveness and lead to candor and trust. Unfortunately, there are fewer handicapped staff in legal services than elderly staff—only 10 percent to 15 percent of the programs have any handicapped staff of a specified type: lawyer, paralegal, other. Very few programs (under 10 percent) have made any facilities modifications to accommodate handicapped staff.

The LSC regulation covering facilities accessibility also prohibits employment discrimination against the handicapped and requires a program to make "reasonable accommodation" to the limitations of a qualified handicapped applicant or staff person. Thus, the actions discussed earlier with respect to enforcement of this regulation, training and technical assistance cover the problems discussed here.

Finally, significant access difficulties may occur for the handicapped, particularly the mentally disabled, because of the intervention of surrogates, relatives, friends, or guardians whose interests conflict with those of the handicapped person. This is particularly a problem with the institutionalized handicapped although it can apply to the noninstitutionalized.

For the noninstitutionalized handicapped, the most common surrogate is a parent or guardian of a minor or mentally disabled adult. Experience in a number of areas shows that a working relationship between a legal services program and handicapped interest and advocacy groups tends to reduce but not eliminate inappropriate interference by surrogates. Two reasons for reduced interference are: (a) The surrogates generally have the best interest of the handicapped person in mind, and education of the surrogate breaks down hostility or reluctance to use legal services; and (b) the advocacy organizations can in some instances bring the disabled person and the legal services program together directly to prevent control by the surrogate.

The policy action of LSC with respect to outreach meets this barrier to the extent possible.

Based on the foregoing discussion, the following is a synopsis of findings with respect to the special difficulties of access of the handicapped.

Overall, the handicapped appear to have sufficient access to legal services although there is insufficient service to the severely disabled. However, there are specific special access difficulties of the handicapped that should be addressed. First, some LSC facilities are inaccessible to the handicapped generally and most are inaccessible for those with severely impaired sight, hearing or speech. This access difficulty is particularly responsible for under-service to the severely handicapped.

Second, there is a significant problem with mobility that is addressed only in some areas. It is best addressed by outreach to handicapped interest and advocacy groups.

Third, with respect to the mentally disabled in particular, there may be access difficulties caused by program policies, staffing type and attitudes. Barriers in this area require continuing development of priorities within LSC, more employment of handicapped staff and ongoing contact with handicapped interest and advocacy groups. Similarly, the fourth type of barrier—inappropriate intervention of surrogates—is prevalent in some areas for some types of handicapped and should be addressed by outreach to advocacy and interest groups.

C. Unmet Special Legal Problems

Legal rights for the handicapped, efforts to bring them into the mainstream of society and defend them from ongoing discrimination, are recent developments. Reflecting these developments is a tendency to equate the important special legal problems with areas where new legal rights are present or are emerging. Thus, based on site visits, interviews with national organizations and questionnaires to local organizations, the areas judged most important are the areas of newly created or emerging rights: education, employment, facilities accessibility, transportation and rehabilitation and habilitation services. The only area that doesn't reflect this tendency is income maintenance.

The following is a brief overview of the nature, scope and complexity of legal problems in each of the areas and a synopsis of the extent to which such problems are addressed by legal services:

(1) *Income maintenance.*—This is a traditional area of legal services involvement. Most of the programs for the handicapped, or subcategories thereof, are shared with other groups (usually the elderly). As a result there is a broad client base that necessitates specialization by programs. The recurring problem—establishing disability—is usually met both by the LSC program and by some members of the private bar who will take some cases for a percentage of the lump sum recovery.

Overall, the problems in this area are being addressed.

(2) *Education.*—Rights to an appropriate education tailored to the specific needs of the handicapped child are of recent origin under the Constitution (as interpreted by some courts), the Federal Education for All Handicapped Children Act and some State statutes. The services needed involve education of parents, counseling, representation in administrative hearings, representation in litigation and representation of groups with respect to policies and legislative actions. All these services are delivered though the law is yet unclear on many major issues.

Education has probably been the chief area of the developmentally disabled P&A systems, yet they meet only part of the need. Because of limited resources they have largely excluded some handicapped children—e.g., those with learning disabilities, or the blind. Involvement of LSC programs has been sporadic despite much more national support involvement—through the Center on Law Education—than on any of the other issues discussed here.

To a great extent, the need in this area remains unmet.

(3) *Employment.*—The Rehabilitation Act and regulations implementing it prohibits employment discrimination by Federal contractors and grantees and in Federal employment. State statutes in a number of States prohibit employment discrimination against the handicapped generally.

Primarily, the need in this area is for litigation representation of applicants or employees with legislative/administrative representation at the State or local level to establish the handicapped's rights. Few LSC programs show any activity in the area. Nor has employment discrimination been a particularly high involvement area for P&A systems. Even if it were, most of the physically handicapped would be unlikely to receive service from the P&A systems. There is some national support available in this area from the National Employment Law Project and from the private support entities—e.g., National Center for Law and the Deaf.

The need in this area is almost wholly unmet.

(4) *Facilities accessibility/transportation.*—As with employment, the rights flow primarily from the Rehabilitation Act and implementing regulations, although other Federal statutes can be involved and some States have passed similar statutes. Transportation is included here because in one sense it is an example of a specific facilities accessibility problem. There may be a need, however, for comprehensive advocacy services to ensure that transportation planning includes the handicapped and fairly addresses their needs.

Unlike employment, however, this is primarily group advocacy. Much of the litigation done in this area has been controversial as well as lengthy and complex, requiring a substantial resource commitment.

Some work on facilities accessibility has been done by P&A systems but mostly they have avoided complex and lengthy litigation. There is also some activity in legal services programs. Generally, the need is unmet.

(5) *Habilitation/rehabilitation services.*—The nature of the legal problems in this area is unclear. Various Federal and State programs establish rights to habilitation programs. Their purpose is usually to enable the handicapped person to live independently, be self-supporting and remain in the community. The overall perception is that these programs often don't accomplish their purpose and legal advocacy is necessary to ensure they will.

There is, however, no typical problem one can describe to discuss the services necessary to resolve it. This is an emerging area and, presumably, a full range of services including education, counseling, litigation representation and legislative and administrative representation will be necessary. To some extent the P&A systems are trying to address the need. Their role has been largely to comment on regulations and handle individual complaints for the developmentally disabled. LSC programs have done virtually nothing in the area. Most of the need in the area is unaddressed.

Overall from this discussion, it is clear that the special legal problems judged to be the most important for the handicapped are largely unaddressed. With respect to LSC programs, the reason for limited service appears to be lack of demand and lack of expertise. While either of these reasons can be labeled as the cause of the other, it is clear they have a symbiotic relationship.

If outreach is initiated to alleviate some of the access problems discussed earlier, improvement is likely because of the strong interest in these issues. When there has been an ongoing relationship between handicapped organizations and a legal services program, invariably the special legal problems begin to be addressed.

There will, however, be a need for training and support. At present there is no basic source of information or training on most of the issues. Support is available on some of the issues but not on all. Thus, the following actions are appropriate:

> If increased money is available in future years for national support, high priority will be placed on covering all issues of concern to the physically and mentally handicapped. The support capacity will include coverage of delivery issues. Among the methods of implementation to be explored are use of existing LSC centers and programs, use of non-LSC centers and separation (or integration) of physically and mentally disabled, and
>
> LSC will create a manual on the major issues of concern to the physically and mentally handicapped. The manual will be followed by national training, strategy seminars and trainer training.

To encourage programs to address the special legal problems, there needs to be some focus from LSC nationally. Accordingly:

> LSC will actively participate in the United Nations sponsored International Year for Disabled Persons in 1981 with appropriate activities.

IV. INSTITUTIONALIZED ELDERLY AND HANDICAPPED

A. Background

To define "institutionalized" the study uses the definition adopted by the Bureau of Census for an "Inmate of an Institution":

> [A person] under care or custody in [an] institution . . . regardless of the number of people in that place.

The census goes on to create a list of institutions with appropriate definitions. The list includes: (1) Correctional institutions, (2) mental hospitals, (3) residential treatment centers, (4) tuberculosis hospitals, (5) homes for the aged and dependents, (6) homes and schools for the mentally handicapped, (7) homes and schools for the physically handicapped, (8) homes for neglected and dependent children, (9) homes for unwed mothers, (10) training schools for juvenile delinquents, and (11) detention homes for delinquent children.

This study is concerned primarily with persons who are institutionalized because they are elderly or handicapped. This specification includes persons in institutions labeled (2) through (7) and (9). While there may occasionally be some consideration of other institutionalized elderly or handicapped (for example, prisoners who are treated for mental illness), the primary focus is in these categories.

As with the noninstitutionalized elderly and handicapped, some concept of limited income or wealth must be applied to the institutionalized. However, the term "poverty," which is the normal reference point for eligibility, is inappropriate to the institutionalized because all or most of the necessities of life are supplied by the institution, often at no cost to the institutionalized person.

There is some national level income information available on the institutionalized. It shows that few institutionalized have any substantial income. For this reason, the study adopts the approach that income and/or wealth can be ignored for purposes of drawing conclusions about access difficulties, unmet special legal problems and policy recommendations. This is not a finding, however, that no means test should be imposed on the institutionalized for determining eligibility for legal services. It is instead a determination that such a small percentage of institutionalized persons would be ineligible under any means test imposed that they can be ignored for purposes of this study.

Based on figures from the 1976 Master Facilities Inventory compiled by HEW, there are 1,829,117 institutionalized elderly and handicapped persons in the country, excluding those who are in psychiatric, chronic disease or alcohol/drug treatment wards of general hospitals. Of these, the vast majority—1,320,141—are nursing or custodial care homes, including homes for the aged. The remainder are in mental hospitals, other facilities for the mentally ill, schools and residential facilities for the mentally retarded, tuberculosis and other chronic disease hospitals, alcohol and drug treatment facilities, schools and other facilities for the physically handicapped and homes for unwed mothers.

There are a number of significant trends in the institutionalized population. The first is a decline in population in the larger—usually public—institutions offset by substantial increases in the population of smaller—often private—facilities. Thus, the population in mental institutions was cut in half from 1970 to 1976. On the other hand, the population in nursing and community care homes rose approximately 340,000 persons over the same period.

The result of this trend is that a typical institution is a small community facility. The 1.8 million institutionalized persons are in 27,203 institutions with an average population of 67 persons per institution.

The second trend is a continuing increase in the overall size of the institutionalized population despite shifts in the type of institutions involved. Thus, the 1976 institutionalized population is 107,000 persons larger than that enumerated in the 1970 census.

LSC and its predecessors placed no particular emphasis on the institutionalized. In fact, as discussed below, the omission of the institutionalized from counts used for funding may be taken as a policy that programs funded by LSC have no responsibility to serve the institutionalized. Some programs have served the institutionalized or brought cases which affect them. Also legal services have sometimes been available through other sources. All but one State provide counsel to indigents when they seek to commit a person to a mental institution. Thirty-six States provide counsel to indigents they seek to commit to an institution for the mentally retarded. In both instances, the usual policy is to appoint private attorneys although a number of States use public defenders or other agencies and a small number use LSC programs.

The right to representation may extend beyond proceedings for commitment, to obtain release or periodic reviews of statutes. In a few States (for example, New York and New Jersey) the State created system may provide counsel for other problems.

Federal programs are responsible for some legal services for the institutionalized. The Developmentally Disabled Protection and Advocacy Systems provide legal services for the institutionalized developmentally disabled in some States. HEW has started some mental health legal advocacy demonstrations, some of which serve the institutionalized. The AoA initiatives in nursing home ombudsmen services have resulted in limited legal services in some areas.

Also there have been private sector initiatives. The largest was the ABA Commission on the Mentally Disabled bar funding program which used foundation money for demonstration programs to provide legal services to the mentally disabled. Some of these projects served the institutionalized.

Finally, there are local programs established with a combination of resources. They are most likely to be present in large health institutions and rely on State and local funding.

While there are no definitive estimates of the extent to which the need is met by these various efforts, it seems clear that they barely scratch the surface. They are aimed almost exclusively at persons in the large institutions which increasingly house only a small share of the institutionalized population in any area. Except for the State provided commitment defense, it is unlikely special legal services exist for the institutionalized in any given area, even in the large public institutions.

B. Special Difficulties of Access

The major special access difficulty of the institutionalized is obvious—either because of the condition that resulted in institutionalization, the law or institutional rule, they cannot go to a service provider. Institutionalization also means the person is not likely to be informed of services. Institutionalized persons also may be unaware of legal rights and how to vindicate them.

As a practical matter, the only effective solution to this access problem is to bring services directly to the institutionalized person, including representation, publicity and legal education. While some institutionalized persons may be mobile and may in theory be able to go to the office of a service provider, this is too much to expect from all but a very small segment of the institutionalized population.

The extent to which LSC programs meet the barrier by bringing services directly to the institutionalized varies markedly by type of institution:

(1) *Institutions for the mentally ill.*—Roughly 30 percent of the LSC programs having one or more institutions for the mentally ill in their service area provide some services to the residents of the institution. A small percentage (under 5 percent) have established an office at the institution. About 20 percent conduct case intake at the institution. On average, this circuit riding intake occurs twice per month or less. About 10 percent to 15 percent of the programs reach the residents of the institutions with publicity or education activities (usually a pamphlet on legal rights).

(2) *Institutions for the mentally retarded.*—Less than 20 percent of the LSC programs having one or more institutions for the mentally retarded in their service area provide any services to residents of such institutions. Roughly one program in 100 has an office in the institution. About 6 percent of the programs conduct case intake at the institution. Less than 10 percent reach the residents of the institution with publicity or education activities.

(3) *Treatment centers for alcoholics or drug abusers.*—Service to residents of these institutions is very rare. Less than 10 percent of the LSC programs extend any service at such institutions. Less than 5 percent conduct case intake at the institution. Roughly 5 percent to 7 percent reach the residents with publicity or educational activities.

(4) *Nursing homes.*—A third of the LSC programs provide some services to residents of nursing homes in their area. About 20 percent conduct case intake at such institutions. However, this is primarily an "on call" service with sporadic, short duration trips to the facility. Essentially, these are "home visits" to persons who happen to reside in nursing homes.

About 20 percent of the programs reach the residents of nursing homes with publicity or legal education materials. Over half of these programs do not conduct case intake at the home.

(5) *Community care homes including homes for the aged.*—About a quarter of the programs having one or more facilities of this type in their service area extend some service to the residents. Roughly 20 percent conduct case intake at these homes. Again, the visits are sporadic and of short duration, like a "home visit" to persons that happen to be in community care homes. About 15 percent of the programs publicize services or conduct educational activities at these facilities.

The pattern of service (or nonservice) is clear. Irrespective of the type of institution, the likelihood is that a resident will have no access to services of the local LSC program. Those most likely to have some access are residents of mental institutions or nursing homes. Even with respect to these facilities, however, the number of programs engaging in systematic intake at the institution is minute.

The major reason for lack of service to the institutionalized is probably lack of funding for this population as discussed below. It is important to emphasize, however, that it is often the institution that refuses access to the legal services staff. This is particularly true of small, private facilities. Because it is otherwise difficult to reach these small, scattered facilities in an effective way, programs may not challenge refusal to give access.

Based on this finding, the following recommendation is made:

> To alleviate the physical barriers to access to legal services faced by institutionalized persons, LSC recommends that Congress enact legislation to ensure legal services staff have access to institutions in which eligible clients reside.

Inability to reach a service provider is not the only access barrier of the institutionalized. As elderly and/or handicapped persons, they have most of the access difficulties discussed earlier under the non-institutionalized elderly or handicapped. Some of these difficulties deserve special mention.

Often it's very difficult to communicate with the institutionalized mentally disabled, and often they lack the capacity to make informed decisions needed to employ counsel and pursue their rights. Not only does this make representation difficult, but it also may render publicity and legal education activities ineffective. Effective service requires extreme care and patience. Even with this care and patience, the lawyer's role is often unclear, requiring a kind of judgment that comes only with time and effort.

There are often surrogates between the lawyer and the client, such as when the client is mentally disabled, elderly or young. Typically, the surrogate is a relative, although non-relative guardians are common in some areas. The actions of the surrogate may be the legal problem and, because of the control given to the surrogate by law, the disabled person is prevented from contacting a legal services provider. Even if the disabled person and the surrogate do not have directly conflicting interests, the surrogate may oppose pursuit of particular rights or use of legal services.

The major reason for the existence of access barriers with respect to LSC programs appears to be the funding allocation policy of LSC. Because of this policy few programs offer access to the institutionalized. The other access barriers discussed above may be a serious problem where a legal services program does offer physical access to services. This is such a minority of cases, however, that these barriers are relatively unimportant *at this time*.

LSC's basic funding allocation formula—often called "minimum access"—awards grants to programs based on the number of poor persons in the program service area. As a matter of definition, no institutionalized person is "poor" and thus, the institutionalized are omitted from the Bureau of Census counts of poor persons that form the basis for LSC funding. By saying that institutionalized persons are not poor by definition, does not mean they can afford legal counsel. Available data indicate that over 95 percent of the institutionalized elderly and disabled lack sufficient income to afford private counsel.

The omission of institutionalized persons from the poverty population and therefore from the LSC funding base has two consequences. It means that all programs are less adequately funded than has been recognized previously. The addition of over 1.8 million elderly and handicapped persons to the pool of eligible persons is no small adjustment; furthermore, this figure doesn't account for all the institutionalized, e.g., prisoners.

The second consequence is an unequal capacity to serve institutionalized persons because they are not distributed in the same way as poor persons generally. Thus, the number of institutionalized elderly and handicapped in the service area of one program is equal to 64 percent of the poverty population. In another, the number is equal to .3 percent of the poverty population.

There are really two aspects of the distribution of institutionalized elderly and handicapped in comparison to the poverty population that contribute to unequal capacity. In LSC's New England region, the median program has in its service area about 13 percent as many institutionalized elderly and handicapped as poor persons. In the Southern region (region VI), the median program has roughly 4 percent as many institutionalized elderly and handicapped in the service area as it has poor persons. Generally, there are many more institutionalized elderly and handicapped, in relation to the poverty population, in the northern tier of the states than in the southern states.

The second difference is intraregional and even intrastate. This is especially true in states or regions with programs covering a relatively small geographical area (e.g., one or two counties). For example, in the regions covering New York, New Jersey, and Pennsylvania, there are programs where the number of institutionalized elderly and handicapped is over 25 percent of the poverty population; in contrast there are also programs where it is under 5 percent.

Looking at both interregional and intraregional differences, the following picture emerges. The capacity of a program to serve the institutionalized depends on whether the program is in the northern part of the country or the southern part and then on more local factors like intrastate placement of institutions.

Given the unequal impact of the institutionalized on programs not funded to serve them, it is unrealistic to expect the programs, especially those having relatively high institutional populations, to serve the institutionalized without additional funding. Therefore:

> LSC will develop a plan to achieve full coverage for the institutionalized. Funds for partial implementation were sought in the 1981 budget request. LSC will seek additional funds in future budget requests until the plan is fully implemented.

If appropriation for the institutionalized is available, LSC will have to design a plan to determine appropriate grantees, nature of delivery system, populations covered, etc. While it is premature to determine the nature of the plan, it is important for LSC's involvement over the long term to be somewhat limited. While current resources available for legal services for the institutionalized don't begin to meet the need, they should not be supplanted by LSC funded programming. Further, the typical level of per capita funding for legal services for the institutionalized is quite high (based on average population). It is unrealistic to expect LSC to obtain and distribute the $100 million plus level of resources that would match the level of funding now common for institutional programs. Therefore:

> LSC will affirmatively seek out funds from Federal and other sources to increase the funding of programs (whether LSC funded or not) that provide representation to the institutionalized.

Besides taking into account both LSC and non-LSC funds, the plan should be tailored to LSC's ability to plan, develop, and monitor programs serving the institutionalized. The plan should be based on delivery methods that have proven effective as well as innovations and improvements in delivery that will develop with experience. The plan should provide service to all institutionalized populations and assure funding of a fair mix of different types of institutionalized persons. A clear preference should be given for delivery systems which involve joint participation by current LSC programs. Favor should also be given to projects that link together various segments of the institutionalized population, either because they share a common reason for institutionalization or because they have common legal problems.

While there is enough experience both with legal services delivery generally and with delivery of legal services to the institutionalized to ensure that efficient and effective delivery systems can be established for the institutionalized, it is appropriate with any new endeavor to invest some resources in creating a technical assistance capacity on delivery of services. This kind of assistance will help avoid some of the access problems that would hinder effective service. Therefore:

> LSC will seek to establish a sufficient capacity for technical assistance on substantive issues, delivery system assistance, and national and state support for the institutionalized. The development of this capacity will be dependent upon the amount of funds appropriated for the institutionalized and for other categories of LSC's budget.

Finally, it is unlikely in the small, community facilities in which the institutionalized overwhelmingly reside, legal services programs can give access to every resident in every institution. This is an access problem akin to that of migrant farmworkers in labor camps.

One solution to the difficulty of providing access to the small, scattered populations involved is to rely on other advocates who have greater access to residents. Accordingly:

> LSC will affirmatively seek to cooperate with other federal and state agencies involved in programs of advocacy or assistance to the institutionalized (such as the nursing home ombudsman program operated through AoA).

C. Unmet Special Legal Problems

Where there is almost no access to legal services for the vast majority of the institutionalized, it is almost hypothetical to talk about unmet special legal problems. All legal problems, special or otherwise, are generally unmet except in those instances like commitment defense where the state has assumed a specific responsibility to assure provision of service.

One can divide the special legal problems of the institutionalized into three categories as follows: (1) Those connected with the process of institutionalization or commitment; (2) those arising as a result of residency in the institution; and (3) those connected with release from the institution.

Special legal problems in the first category are probably addressed to the greatest degree partly because the eligible person is in the process of institutionalization and may have access to legal services. Thus, a lot of LSC programs handle cases connected with, for example, medicaid eligibility to enable a person to enter a nursing home.

The first category also includes cases where the state typically provides counsel. This does not, however, mean the legal problems are sufficiently addressed. In fact, the adequacy of representation of counsel in commitment hearings is under challenge in a number of states.

Problems in the second category are not addressed generally because of the lack of access. Some of them—for example, the adequacy of institutional conditions—are major and will not be resolved simply by creating access to legal services. The legal services provider must have sufficient expertise and resources to address large, systematic issues often through protracted litigation.

Problems in the last category are probably addressed the least because of lack of access and the nature of the problem. Despite a commonly expressed adherence to the principle of the least restrictive alternative, many persons remain in institutions when they should be in far less restrictive settings, often outside institutions altogether. Many others are released to improper or woefully inadequate placements. Turning a right to a proper placement into the reality requires not only access to legal services but also skillful and imaginative counsel who understands the various options and resources required. At this point, such legal services appear to be very rare.

It is important to emphasize that even if access to legal services is achieved for the institutionalized, effective services that directly address the important special legal problems of the institutionalized will not automatically appear. Development of expertise—both in the substantive problems and in relating to the client group—along with a great deal of imagination will be prerequisites to effectiveness.

Based on this finding:

> LSC will seek to establish sufficient capacity for national and state support for services to the institutionalized. The extent of the capacity will depend on the amount of funds appropriated for the institutionalized and other budget categories.

V. METHODOLOGY AND DATA USED IN THE STUDY

A. Methodology

This part of the study was also conducted by the Research Institute of LSC. The process of issue development utilized earlier to study the five section 1007(h) groups was identical for this study of the elderly and handicapped.

The information collected and analyzed in the course of the study came from eight main sources:

(a) The existing literature bearing on legal services for or legal problems of eligible elderly or handicapped persons.

(b) Legal Services Corporation records, primarily grant applications.

(c) Questionnaires to a sample of LSC funded field programs.

(d) Questionnaires to area aging agencies, organizations and groups of elderly persons, and groups and organizations concerned with the interests of handicapped persons (usually a segment of the handicapped, such as the blind).

(e) Information collected by LSC's delivery systems study on cases handled by a sample of staff programs.

(f) Interviews conducted in 16 areas of the country. Included among interviewees in most areas staff delivering legal services to the elderly and/or handicapped (whether or not in LSC-funded programs); management and supervisory staff of the LSC-funded program in the area; area aging agency staff; persons delivering services to the elderly and/or handicapped; advocates of the elderly and/or handicapped; and others knowledgeable about the access difficulties or special legal problems of the elderly or handicapped.

(g) Enumerations and other demographic information primarily from the 1970 census, Current Population Surveys (conducted by the Bureau of the Census), the Survey of Income and Education (also conducted by the Bureau of the Census) and the Master Facilities Inventory (gathered by HEW).

(h) Interviews with knowledgeable and interested persons with a national perspective. Most of the persons interviewed in this category are in Washington, D.C.

As with the other groups, the basic methodology is to draw on all these information sources to the extent possible, and to specify the important special legal problems and determine the degree to which they are now being addressed. The interviews and questionnaires were also used to obtain informed opinions on the appropriateness of possible actions by LSC.

It is important at the outset to recognize limitations inherent in the methodology. There is enormous variation around the country with respect to any issue addressed in the study. The multiplicity of information sources, and the information from the site visits particularly, are invaluable to show national trends and the range of variation. Indeed, without information from many areas and many people, national conclusions would be wholly inappropriate. On the other hand, there is no precise scientific method at work here. Further, the variation and diversity is so substantial that any conclusions that attempt to describe a phenomenon as national are wrong in many places. In fact, as will be seen, the promise of multiple information sources appears illusory when the information from different sources disagrees dramatically on a particular issue.

F. Data and Information Used in the Study

Technical questions of data reliability and accuracy will be discussed in an appendix to the report. Included are approximations of sampling error for the LSC program information obtained by survey by the Research Institute; for the case and client type information obtained by the delivery systems study; a display of response rates for the various questionnaires, sampling error for these questionnaires to the extent applicable, and conclusions about reliability based on these factors; and a discussion of strengths and weaknesses of the demographic information used in the study.

Some aspects of the information base of the study necessitate some textual discussion or elaboration. They are discussed in the following subsections.

(1) *The site visits.*—The report relies heavily on information gathered during the site visits. The site visits had a definite purpose in the study. The areas visited were chosen because there was some special activity within the LSC-funded legal services program, or another program, for the elderly and/or handicapped. As a result, neither the areas nor the programs within them should be viewed as typical of the country or legal services as a whole. In fact, it is not clear the areas are typical of places where special legal services attempts to help the elderly and/or handicapped have occurred.

What these areas and programs show primarily is the effectiveness of various methods to deal with access difficulties and special legal problems as viewed from a number of perspectives. Because sixteen areas were visited, most methods were observed more than once and under different circumstances.

The site visit interviews also gave the Research Institute the opportunity to explore many persons' attitudes and perceptions with respect to the interview questions without the limitations of a written survey instrument. Those attitudes and perceptions were gathered by over a dozen different people, most of whom visited more than one area. The interviewers generally were persons who are knowledgeable about legal services for the elderly and/or handicapped and their own perspectives were combined with that of the persons they interviewed to give the study additional information.

Finally, while the areas were chosen because of some special activity for the elderly and/or handicapped, there were always gaps which permitted the interviewers to observe the situation without special activity. For example, in some areas there were special units for the elderly but none for the handicapped. In others, there were special units for the mentally handicapped but none for the physically disabled. While it is not necessarily intended, the interviews showed as much about access and special legal problems where no targeted legal services activity was occurring as they did where there was special activity.

While the interviewers had two written instruments (one for the elderly, the other for the handicapped), they were used only as guidance. Ultimately however, the written instruments were used to record a composite of the information obtained during the interview. These instruments show varying points of emphasis and degrees of completeness depending primarily on the interviewees. In some areas, the interviews were slanted toward legal services providers and agencies funding legal services (e.g., area aging agencies, developmental disabilities councils). In other areas, the interviews were primarily with clients, client groups, advocacy organizations and the like. The differences were determined primarily by the availability of interviewees, the number of potential interviewees within a category, the time available for interviewing, etc.

(2) *Use of surrogates.*—Under ideal circumstances, one would want to determine the needs of persons eligible for legal services assistance by direct questioning. In a national study of this type one can rarely produce this ideal; there is a constant use of surrogates—that is, persons who to some degree, speak for eligible persons within the surveyed group. There are actually two types of surrogates used in this section of the study: (a) Those who are surrogates for individuals in the handling of legal problems—e.g., parents and guardians; (b) those who, because of their position, are expected to speak for the interests of eligible persons generally but are not usually individual intermediaries.

During this phase of the study, information was often obtained from persons who are surrogates in both senses. In many cases an information source is both acting as a surrogate and speaking from an independent perspective. Whenever information was obtained through surrogates—whether by personal interview or written questionnaire—the interviewers evaluated the interests of the surrogate and viewed the information received in light of this evaluation.

(3) *Absence of comparative information on poor persons not studied.*—Probably the most important point that can be made about the data is that it is limited solely to the groups under study. This means it is impossible to say anything that compares the situation with respect to the elderly and/or handicapped with the situation with respect to other poor persons.

It is indeniably difficult to keep this point in mind and to adhere to its meaning. It 50 percent of questionnaire respondents say, hypothetically, that elderly persons have insufficient access to legal services, one wants to read into this statistic not only that there is a serious access problem for the elderly in need of correction but also that the problem must be more serious than for other poor people. One only has to review the answers given to that question by other groups to see that the latter conclusion is probably wrong, at least in relation to some poor persons. Even the former conclusion—at least in the use of the label "serious"—is also wrong or simplistic if it conveys any sense of relative urgency about the problem.

To a certain extent, the lack of comparative information and the resulting limitation on the use of data about the elderly and handicapped reduces the need for data precision. Conclusions are based largely on relationships in the data rather than absolute values. Thus, the extent to which the elderly may judge access to a program as sufficient is less important that the reason for that judgment. Reasons that recur are treated as significant even if others recur more frequently.

VI. ACTIONS AND RECOMMENDATIONS

The policy decisions and implementation steps below were discussed within the body of this summary text for each group studied. This section lists the recommendations made and the actions planned to fulfill the findings of the study. Following each recommendation the LSC division with principal responsibility for its implementation is indicated in parentheses.

A. Noninstitutionalized Handicapped

Specific actions

(1) LSC will clarify the auxiliary aids requirement contained in its section 504 regulations to provide more specificity for the guidance of recipients (General Counsel).

(2) LSC will develop and disseminate a technical assistance manual on section 504 compliance by June 1, 1980 (Equal Opportunity Office and General Counsel).

(3) Following the development of the technical assistance manual, LSC will train one staff person in each regional office to disseminate information to programs to encourage local compliance with section 504 and provide technical assistance on request (Office of Field Services).

(4) As currently planned, the monitoring process will cover compliance with section 504. One person who is part of the monitoring process should be sufficiently familiar with section 504 requirements to determine program compliance (Office of Field Services).

(5) LSC will make its Washington facilities and activities fully accessible to the handicapped including the purchase of a TTY machine and the dissemination of information in such a way as to reach those with sight or hearing disabilities. Each of the regional facilities and activities will be evaluated on their accessibility to and effect on handicapped persons. To the extent necessary, regional facilities and activities will be made accessible (Office of Administration).

(6) If increased money is available in future years for national support, high priority will be placed on covering all issues of concern to the physically and mentally handicapped. The support capacity will include coverage of delivery issues. Among the methods of implementation to be explored are use of existing LSC centers and programs, use of non-LSC centers and separation (or integration) of physically and mentally disabled (Research Institute).

(7) LSC will create a manual on the major issues of concern to the physically and mentally handicapped. The manual will be followed by national training, strategy seminars and trainer training (Office of Program Support).

(8) In order to encourage programs to engage in outreach to handicapped advocacy groups, to provide education, publicity, and attendance at meetings, and to increase representation, the regional office person trained on section 504 compliance will also be knowledgeable about service delivery structures and policies that are effective and responsive in serving the handicapped and will be prepared to provide technical assistance in this area (Office of Field Services).

(9) LSC will actively participate in the United Nations sponsored International Year of Disabled Persons in 1981 with appropriate activities (Executive Office).

General policy questions

(1) In evaluating improvements and changes in the monitoring process, LSC will consider a process to increase efforts in obtaining the views of clients, advocates and other community people who are not part of the program staff (Office of Field Services).

(2) In evaluating improvements and changes in the monitoring process, LSC will consider more detailed examination of activities covered in whole or in part by non-LSC funds and involving persons who are knowledgeable about such activities (Office of Field Services).

(3) LSC will reevaluate the priority setting process it currently requires and/or recommends in light of the findings of this study (Office of Field Services).

(4) LSC will evaluate the feasibility and propriety of developing recommendations on delivery systems to meet the needs of special groups and on methods to accommodate the needs of special groups in the development and implementation of LSC policy (Executive Office).

B. Noninstitutionalized Elderly

(1) As part of a general effort to define the civil rights responsibilities of programs, LSC will enact a regulation to enforce the Age Discrimination Act (General Counsel).

(2) LSC will inform all programs of their obligations under the Age Discrimination Act and the Age Discrimination in Employment Act (General Counsel).

(3) The current process within the Office of Field Services to redesign LSC policies on program priorities and planning will seek to simplify the recom-

mended process and emphasize results, not procedure (Office of Field Services).

(4) LSC will work with the Administration on Aging to help develop an effective legal services network and to encourage local area aging agencies to support aggressive, quality legal services for the elderly (Office of Field Services).

(5) LSC will seek to establish with the Administration on Aging a national support structure that will assure that LSC grantees receiving AoA funds, as well as other AoA grantees providing legal services, have access to effective training, technical assistance, cocounseling, coordination and communication on issues affecting the elderly. LSC will attempt to gain AoA assistance in funding a national support structure that will provide advocacy (including legislative and administrative representation) on a national level on elderly issues (Research Institute).

(6) LSC will continue, consistent with its process for the allocation of funds, to provide funds to existing support centers to assure that adequate support and advocacy are undertaken on age-targeted issues, such as age discrimination, pensions, medicare, long-term care (Research Institute).

(7) To the extent funding is available for substantive training and the development of manuals, LSC will develop manuals and training on the special legal problems of the elderly (including, particularly, issues not covered in previous training). The training will be open and the manuals available to those in special elderly units as well as to generalist staff within local programs (Office of Program Support).

C. Institutionalized Elderly and Handicapped

(1) LSC will develop a plan to achieve full coverage for the institutionalized. Funds for partial implementation were sought in the 1981 budget request. LSC will seek additional funds in future budget requests until the plan is fully implemented (Executive Office and Office of Field Services).

(2) LSC will seek to establish a sufficient capacity for technical assistance on substantive issues, delivery system assistance and for national and state support for the institutionalized. The development of this capacity will be dependent upon the amount of funds appropriated for the institutionalized and for other categories of LSC's budget (Office of Field Services and Research Institute).

(3) LSC will affirmatively seek funds from federal and other sources to increase the funding of programs (whether LSC funded or not) that provide representation to the institutionalized (Office of Government Relations).

(4) LSC will affirmatively seek to cooperate with other Federal (and State) agencies involved in programs of advocacy or assistance to the institutionalized (such as the nursing home ombudsman program operated through the Administration on Aging) (Office of Government Relations).

(5) To alleviate the physical barriers of access to legal services faced by institutionalized persons, LSC recommends that Congress enact legislation to ensure legal services staff have access to institutions in which eligible clients reside.

ITEM 24. NATIONAL ACADEMY OF SCIENCES

DECEMBER 15, 1980.

DEAR MR. CHAIRMAN: Thank you for again inviting the National Academy of Sciences to contribute to part 2 of your report, "Developments in Aging," 1980 edition. As has been indicated in earlier responses, the National Academy is not a Federal agency, rather it is a nonprofit, private organization operating under a charter issued by the Congress in 1863 to provide advice to the Federal Government on matters of science and related technology. Nevertheless, we have felt that it would be useful to report on our advisory programs to the Federal Government that relate to aging.

In response to a similar request in December 1978 and 1979, information was provided concerning the establishment of a Committee on Aging within the National Research Council's Assembly of Social and Behavioral Sciences. Current Academy programs that relate to aging include the study entitled "Mammalian Models for Research" and the program presented at the Food and Nutrition Board annual meeting on December 8, 1980, as described by Dr. Councilman Morgan of the Assembly of Life Sciences in his letter to you of November 20,

1980. The program included a symposium on nutrition and the aging covering an overview of the aging process, cellular mechanisms in aging, and dietary factors affecting the aging process together with a panel discussion on nutrition programs for the aging. Panelists participating were from the White House Conference on Aging, the U.S. Department of State, the National Association of Retired Persons, George Washington University, the Gerontology Research Center, Tufts University, and the National Institute on Aging.

The Assembly of Behavioral and Social Sciences has completed a three-volume report on the workshops referenced in our letter of December 31, 1979. These volumes are now in press and will be published by Academic Press in mid-1981. The Assembly has plans to pursue its work in support of Federal programs related to aging and is negotiating arrangements with the National Institute of Aging for continuation of the Committee's work. In addition continuing committee efforts to strengthen the contributions of the behavioral and social sciences to the study of aging, the formation of four panels is proposed to consider topics such as: Aging and formal organizations, gentics and aging behavior, the aging brain and behavior, methods of analysis of longitudinal and cohort studies, and close relationships in the family.

In response to a request from the National Institute on Aging, a study is underway in the Institute of Medicine on the scientific evidence relevant to mandatory age retirement for airline pilots. Through a committee with expertise in the fields of aviation medicine, the study will outline the nature of the problem, develop criteria for evaluating scientific information relating to pilot performance, review the significance of existing studies, and indicate research that might provide more precision in future evaluations of medical and psychophysiological factors affecting performance. The committee will consider the medically and behaviorally important characteristics and factors relevant to airline pilot performance with specific attention to the relationship of the incidence of those factors to the aging process. A final report is scheduled to be submitted to the National Institute on Aging by March 1981.

The above are the three areas in which the National Academy of Sciences is currently engaged in work relating either directly or indirectly to the problems of the aged or aging. Please do not hesitate to let us know if we can be of any further assistance to the Special Committee on Aging.

Sincerely yours,

PAUL L. SITTON, *Executive Officer.*

ITEM 25. NATIONAL ENDOWMENT FOR THE ARTS

JANUARY 27, 1981.

DEAR MR. CHAIRMAN: It is my pleasure to have the opportunity to share the Arts Endowment's efforts for our older population with the Special Committee on Aging. Enclosed is a summary of the Endowment activities specifically related to older Americans.

Recent congressional hearings on "The Arts and the Older American" found the Endowment's efforts to be substantial for our older constituency. Further, the very effective testimony given by Mrs. Mondale, our National Council members, Endowment staff, and grantees concerning the many benefits of professional arts programs prompted committee chairman, Congressman Mario Biaggi, to state that he "will seek to expand the definition of social services under the Older Americans Act to include arts and cultural services to permit senior centers to provide these services." Such an action and such leadership would be a landmark, greatly increasing the number of quality arts programs for our senior population.

In my testimony to the Subcommittee on Human Services of the House Select Committee on Aging last February, I said that "we strongly believe that the arts should be viewed in much larger context—as employment and volunteer opportunities for older people; as new learning experiences; as potential second and third career options; and as elements essential to the general physical and mental well-being of older citizens. But, above all, we should emphasize how the arts serve to enrich lives and how their benefits serve to open new horizons for all who participate."

The Endowment continues to increase its funds for programs that involve elder adults. A total of 124 grants in the amount of $2,124,159 were awarded to arts organizations in fiscal year 1980, and I have included examples of these Endowment-sponsored activities that specifically include older Americans as participants and audiences.

This report also includes information on the cooperative agreement that we developed with the Administration on Aging, the National Endowment for the Humanities, and the White House Conference on Aging. The centerpiece of the agreement is a symposium on the Arts, the Humanities and Older Americans that will be held in Philadelphia on January 31 through February 3, 1981. We view this proposed agreement not only as a unique opportunity to sponsor a symposium which will have nationwide impact, long-lasting results and benefit all concerned, but as the beginning of a partnership among our respective Federal agencies, which will hopefully produce a catalytic response, resulting in cooperative efforts at the regional, State, and community levels. Also attached is a copy of my letter to the executive directors of our 50 State arts agencies and the regional arts organizations.

As you may know, the Endowment was the third Federal agency to publish proposed regulations in the Federal Register which prohibit discrimination by Endowment grantees on the basis of age. These regulations will serve to reinforce our continued efforts to assure that older Americans have as many opportunities in the arts as everyone else.

Be assured that the National Council on the Arts and the Endowment will continue to advocate and support quality arts programming for this very important segment of our society.

We very much appreciate the committee's interest in the National Endowment for the Arts. If we may provide further assistance or information in this matter or in any other regard, please do not hesitate to advise me.

Most sincerely,

LIVINGSTON BIDDLE, Jr., *Chairman.*

Enclosures.

SUMMARY OF ACTIVITIES RELATING TO OLDER AMERICANS, FISCAL YEAR 1980

The Endowment is actively engaged in an effort to make the arts more accessible in the firm belief that the arts can be catalysts in bringing people of all ages closer together, and that this contact between generations contributes to the revitalization of community life. The Endowment encourages State and community arts agencies and arts organizations to seek older people's participation in their programs and services. We understand the value of including older persons as audiences, students, teachers, supporters, volunteers, staff, and creators.

The purpose of the Endowment, as declared in the National Council's statement on goals and basic policy, is to foster "professional excellence of the arts in America * * * and equally to help create a climate in which they may flourish so that they may be experienced and enjoyed by the widest possible public."

The Endowment endeavors to support only works of the highest quality, and we encourage all of our grantees to make their programs accessible to the broadest spectrum of the American population in the firm belief that the arts enrich the lives of all individuals, regardless of age.

Older Americans are currently participating in many programs around the country in which they are instructed by professional artists, such as visual arts, theater, music, dance, creative writing, and crafts. The National Endowment for the Arts and State arts agencies are the primary sources of funding for these projects.

The position of Coordinator of the Office for Special Constituencies was established by the National Council on the Arts in 1976. The Coordinator and her staff work with the Endowment programs, Endowment grantees, State/community arts organizations and other Federal agencies to educate and advocate quality arts programing for older adults, handicapped, gifted and talented, and institutionalized populations. The efforts of this Office include: (1) Providing technical assistance to individuals and organizations needing information and assistance in developing arts programs; (2) initiating cooperative projects with other Federal agencies which serve to educate administrators and professionals serving special constituencies concerning the value and benefits of arts programing for special constituencies; (3) advocating more support for addressing the needs of special constituencies through the Endowment programs, and through State and national conferences, seminars, et cetera, that are concerned with the arts or special constituencies; (4) providing technical assistance to Endowment grantees regarding compliance with Federal regulations concerning special constituencies, including nondiscrimination of older adults, as well as, program accessibility for special constituencies; and (5) providing support for model projects which demonstrate innovative ways to make programs available to special constituencies.

THE ARTS AND THE OLDER AMERICAN HEARINGS

Recent congressional hearings by the Human Services Subcommittee of the House's Select Committee on Aging in February 1980, focused on "The Arts and the Older American." Mrs. Joan Mondale, members of our National Council on the Arts, Endowment staff and grantees gave testimony concerning the value of quality arts programing for older people and contributions of older artists: Witness after witness described how arts programing provides elements essential to the mental, physical, and spiritual well-being of older people. Their testimony led the committee to recommend that arts and cultural services be included in the funding provisions of the Older Americans Act. This action would be a landmark, making it possible for State and local aging agencies to develop more professional arts programs in nursing homes, senior centers, and at nutrition sites. As stated in my testimony to the committee, the arts have a central value:

"All arguments in favor of accessible arts programing and services are as applicable to older Americans as they are to any other age group * * * Older Americans' participation in cultural activities is not an answer to all aging problems, but the arts do heighten self-esteem, stimulate self-growth, and offer exciting opportunities for self-expression * * *. We feel that meaningful creative and cultural experiences should be considered an integral part of the services available to older citizens, and we think this is an issue that the committee and Congress might review."

Attached are copies of the hearing record and the Cultural Post article on the hearing for your information.

The Endowment has continued to support the National Council on Aging's Center on the Arts and Aging for the past 6 years. The Center's Director continues to work effectively with arts and aging organizations to create a national awareness on the importance of including quality arts programs as an integral part of activities supported by State and local aging agencies.

During the past 4 years, over 6,000 artists and aging professionals have participated in this advocacy effort to build partnerships between the two fields. Additionally, the Center's technical assistance efforts have reached all 30 States and territories.

As a direct result of the Director's work, several major aging organizations have established an arts component in the form of a subcommittee or program section: Included are the Gerontological Society, the Western Gerontological Society, and the American Association of Retired Persons.

The primary focus of the Center is not only to involve more older Americans in cultural activities, but to open up new career opportunities for artists in the burgeoning field of aging.

THE ARTS, THE HUMANITIES AND OLDER AMERICANS SYMPOSIUM

There will be approximately 24 million Americans over 65 years of age when the White House Conference on Aging convenes in December 1981. At the previous White House Conference on Aging in 1971, arts and issues of life enrichment were subsumed by other concerns such as housing and health. To assure that cultural activities are on the 1981 agenda, our Office for Special Constituencies developed an interagency agreement with the National Endowment for the Humanities, the Administration on Aging, and the White House Conference on Aging, which I signed, together with the heads of the respective agencies, on September 16, 1980. In essence, the four agencies will plan and implement cooperative arts and humanities programing efforts for older people, including a policy symposium to be held January 31 through February 3, 1981. To be convened by the National Council on Aging's Arts and Humanities Centers, the symposium will focus on the need, demand, and character of arts and humanities programs for our older population. This working conference will bring together experts on the arts, humanities, and aging to: (1) Build a foundation and framework for a mutually supportive working relationship among the fields of the arts, the humanities and the aging; (2) develop policy recommendations for consideration at the 1981 White House Conference on Aging; and (3) propose an agenda for the 1980's in the fields of the arts, the humanities, and aging through the publication of a symposium volume after the White House Conference on Aging.

The conference intends to have results of both a short-term and long-range nature: (1) So that the results of the conference can be fed quickly into the White House Conference on Aging process, a concise report (perhaps 25-30 pages) will be published and distributed at the White House Conference on Aging State and regional meetings. This document will become part of the 1981 White House Conference on Aging working papers and included in the final White House Conference on Aging report; (2) a symposium volume, gathering the more complete papers and proceedings of the conference, will be published late in 1981. Although this volume may not be available in time to influence the White House Conference on Aging deliberations directly, it is intended to be a milestone marking the development of the arts, humanities, and aging and also a touchstone suggesting future directions, stimulating new activity, and identifying important researchable topics. I will be sure that you receive copies of the report and symposium volume.

The most long-lasting result of the symposium and its products, particularly the symposium volume, should be to inform and energize the broad spectrum of artists, humanists, and leaders in aging about the importance, value, and ways to bring the arts and the humanities to older people and vice versa. Certainly, we see the symposium and its products as a blueprint for life enrichment in the 1980's.

In order to complement the policy symposium and assure quality arts and humanities programing for the White House Conference on Aging, the Endowment is also supporting an arts and humanities specialist, who is housed at the White House Conference on Aging Office, to coordinate all arts and humanities activities through the life of the December 1981 conference. Attached is a copy of the interagency agreement for your information.

THE NATIONAL ENDOWMENT FOR THE ARTS' AGE DISCRIMINATION REGULATION

In accordance with the Department of Health, Education, and Welfare general regulations, 44 Fed. Reg. 33768 (1979), the National Endowment for the Arts issued proposed regulations under the Age Discrimination Act of 1975 42 U.S.C. 6101, et seq. The regulations prohibit discrimination on the basis of age in programs or activities receiving Endowment financial assistance. The proposed regulations were published in the Federal Register, October 2, 1979, 44 Fed. Reg. 56725 (1979). Public comments were invited through December 15, 1979. Following the comment period, the proposed regulations were drafted in final form and submitted to the Secretary of HEW for review (this responsibility since has been assumed by the Secretary of the Department of Health and Human Services, HHS). The final regulations currently remain under review by HHS and are expected to be issued in final form pending resolution of certain issues by HHS and the Office of Management and Budget. As stated in my previous report, the Endowment was the third Federal agency to publish proposed regulations in the Federal Register.

ENDOWMENT FUNDING

The Endowment awards grants to arts organizations and individuals through 14 programs such as Expansion Arts, Inter-Arts, Design Arts, Folk Arts and Literature. Each program provides grants in several funding categories, devised to address current and anticipated needs in the field, as well as the goals of the agency as a whole. These categories and their application guidelines are constantly monitored and revised.

Nearly 20,400 grant applications arrived at the Endowment during fiscal year 1980, and more than 87 grant panels reviewed them. Panels in the various programs meet throughout the year and make recommendations on grant applications in an attempt to meet seasonal needs of the field and to distribute the application workload.

The panels serve the individual programs of the Endowment much as the National Council serves the Endowment as a whole. Together the Council and panels provide a system of professional peer review to evaluate applications, identify problems, and develop the policies and programs through which the Endowment responds to changing conditions. Approximately 15 percent of the panel members are 55 years of age and older.

I am happy to report the Endowment has made progress through expanded advocacy and improvements in funding for activities involving older people. It is difficult to estimate the number of Endowment-supported programs that serve older adults, since people of all ages benefit from Endowment grants awarded to a multitude of museums, theaters, performing arts groups, media, and other arts organizations. The Endowment, for example, supports touring groups, particularly in the area of dance and theater, which bring the performing arts to people in smaller communities who otherwise might not travel to a large city to attend cultural programs. In the area of dance, the Endowment provided support to 71 professional dance companies for short residencies in 53 States and territories during fiscal year 1980.

However, many Endowment grants provide arts activities that specifically include older persons as participants and audiences. A total of 124 of these grants in the amount of $2,124,159 were awarded to arts organizations in fiscal year 1980. All of these activities address arts programing for older adults and examples are included in this report.

In addition, hundreds of arts programs for older people at the State and local level are supported through our State arts agency network. We are also seeing a burgeoning interest in arts programing for older citizens on the part of over 2,000 public and private community arts councils throughout the country.

PROGRAM ACCESSIBILITY

Access to cultural opportunities is often denied older adults because of financial, architectural, and logistical barriers. We believe that the Endowment's 504 regulations, which mandate the nondiscrimination of people with handicaps, and our related advocacy and technical assistance work will benefit those older adults with physical limitations by making arts programs more accessible.

The Endowment's design arts program supports architectural research projects, some of which are designed to improve the quality of living for older Americans. One example of a design arts project of this type, is being conducted by Joseph Konecelick from Worthing, Ohio, who is currently researching and writing a book entitled "Aging and the Product Environment" which will allow designers to apply specific criteria to a wide variety of mass produced products for older Americans.

Another example of architectural research under the design arts program is being carried out by Kim Yamasaki from Yoncell, Oreg., who will study the art of design for housing older adults, producing guidelines with drawings and sketches for designers and private groups concerned with the needs of older people.

On each front, the Endowment has sought to remove these barriers through its grant programs.

Specifically, the Office for Special Constituencies supports model projects through the Endowment programs. These projects are intended to develop, implement, evaluate, and document ways of integrating special constituencies into arts activities, both as audiences and participants.

In fiscal year 1980, a total of $300,000 provided 27 model projects through six of the Endowment program areas. Examples of model projects include the Pinellas Arts Council and the Utah Museum of Fine Art.

The Pinellas Arts Council in Clearwater, Fla., provides a technical assistance program offering consultant services to five areas of the State interested in developing a "Revitalize Arts Program" for older people. The program involves artists who travel to nutrition sites and senior centers to offer visual, performing, and literary arts programing to the older population. A 1-day workshop will be held in each area to design county cooperative programs in the arts and aging field.

The Utah Museum of Fine Art/Department of Educational Services in Salt Lake City, are making visual arts more accessible to residents of retirement complexes. The museum will provide exhibits and introductory tours. Interested older adults are encouraged to participate in self-guided research and are trained to act as tour guides for other visitors.

Economic factors are another obstacle to older people's participation in cultural activities. The cost of tickets and transportation may prevent people on fixed incomes from attending performances. Endowment programs continue to support organizations that provide ticket subsidies, schedule programs in places where transportation is not a problem, and offer free or low-cost programs. Examples of these projects include the New Stage in Jackson, Miss., which is funded through our expansion arts program. This program provides low-cost theater tickets and free transportation for 3,000 older people with low incomes, in addition to conducting interpretive discussions for each performance.

Since lack of detailed information on cultural opportunities may further limit the involvement of older people, the Endowment funds many audience development projects. One example is the Brooklyn Institute of Arts and Sciences, which provides a wide-ranging program for the older adult community that includes: (1) An introduction to the museum; (2) workshops on how the museum relates to its community; (3) a seminar on the relationship of the museum's collections to the participants' cultural heritage; (4) an examination of Brooklyn's environmental arts and sculpture; and (5) a Brooklyn Heritage Day that highlights aspects of Brooklyn's cultural diversity.

The following are more examples of projects aimed at providing arts programing for senior citizens. The projects are listed under the Endowment program from which they received their funding.

EXPANSION ARTS

Articulture, Inc., of Cambridge, Mass., offers "Arts for Life," a free performing arts series for senior citizens in housing facilities, nursing homes, hospitals, and in community sites.

Greater Falls River Recreation Commission, Inc., in Fall River, Mass., will continue their comprehensive summer "Street Theater" program of workshops and rehearsals which culminate in a dozen free performances in neighborhood and senior citizen facilities.

Jersey City Cultural Arts Commission in New Jersey sponsored "Summer Festival '80" which included ("Caravans," thrice-weekly performances at senior centers, medical centers and institutional residences throughout the city.

Lettumplay, Inc., of Washington, D.C., produces a series of free community concerts featuring jazz artists and workshops in music in senior citizen centers, hospitals, nursing homes, and prisons.

Piedmont Citizens for Action, Inc. in Worchester, Mass., supports an annual celebration of the arts and culture of Worchester's neighborhoods. Free workshops and concerts are offered in nursing homes and nutrition sites, as well as the annual Elder Extravaganza, a cabaret style celebration for senior citizens in the downtown shopping area.

Quincy Society of Fine Arts in Illinois offers art classes, workshops, and performances benefiting the black and senior populations. Three week-long residencies will occur in senior nursing homes.

Theater Research, Inc./South Street Theater in New York, will produce two one act operas of Victor Herbert, J. P. Sousa, and Pergolesi, and a total of 16 free performances for older citizens and family groups.

FOLK ARTS

Phelps Stokes Fund in New York, will support a series of performances in prisons and senior centers by Afro-Cuban master traditional musician, Julito Collazo and his ensemble. An explanation of cultural traditions and the instruments is included in these performances.

INTER-ARTS

National Council on Aging in Washington, D.C., the Council's Center on Arts and Aging provides information and consultation as well as technical assistance to organizations involved in delivering arts programs and services to older persons.

Hospital Audiences in New York responds to the cultural needs of institutionalized people. It offers several different programs which include bringing art workshops and performances into older people's homes and providing a ticket distribution system for older adults. It also provides technical assistance on programmatic compliance on 504 regulations, and disseminates information on how to evaluate arts programs using Hospital Audience's research on the effect of arts workshops for the frail elderly in nursing homes.

LITERATURE

The artist project of the Cultural Council Foundation in New York supports "Poetry Mobile," in which writers give two readings of poetry per day and onsite workshops in city parks, community centers, hospitals, and senior citizen centers.

MEDIA

The neighborhood film project in Philadelphia, Pa., is providing quality film programing at low admission prices and developing regional audiences by special outreach to senior citizens, community groups, and ethnic minorities.

MUSIC

Arts Alaska, Inc., from Anchorage, Alaska, is touring their chamber ensemble in homes for the aged and the institutionalized in rural Alaskan communities.

Canton Symphony Orchestra Association includes a senior citizen's concert as part of their outreach program.

Des Moines Symphony Association is actively working to increase the number of Sunday matinee subscribers among older people by selling tickets at a reduced price and utilizing 15 buses per concert to bring the older adults to their new civic center.

Eastern Music Festival of Greensboro, N.C., brings Project LISTEN, a weekly series of chamber music concerts, to elderly and handicapped individuals.

El Paso Symphony in Texas is providing general admission seating at the lowest possible cost to senior citizens and military personnel, attempting to develop this audience, as well as that of the Mexican population.

Florida Philharmonic, Inc., of Miami, Fla., holds concerts for their older constituency, and they provide transportation and low cost tickets.

Fort Wayne Philharmonic Orchestra, Inc., in Fort Wayne, Ind., has a core group of 18 musicians which make up four ensembles to perform in schools, senior citizen centers, hospitals, and other locations throughout northern Indiana.

Glendale Symphony Orchestra Association in Glendale, Calif., is opening up dress rehearsals for physically handicapped people and senior citizens, with transportation and other costs provided.

Jacksonville Symphony Association in Florida has expanded its outreach program to include areas such as nutrition sites, nursing and retirement homes, hospitals and public libraries.

Knoxville Symphony Society of Knoxville, Tenn., is touring their young peoples concert program and the KSO Quartet to senior citizen residential facilities.

Monterey Symphony Association of Carmel, Calif., is inviting senior citizens and handicapped students confined to wheelchairs, who are members of the Hartnell College program, to attend concerts as guests of the symphony.

New Muse Community Museum of New York has organized the New Muse jazz heritage program providing instructional workshops, a senior citizens' jazz concert series and a musicians forum.

New York Kammer Musicer in New York City is participating in a 30-day residency in Monmouth County, N.J., which includes free performances in senior centers.

Santa Barbara Symphony Orchestra Association of California has organized a Sunday matinee series for families, students, senior residents, and handicapped individuals. An added capacity of 1,000 seats at the Arlington Theater has made it possible for them to increase courtesy tickets for financially deprived students and special constituents who might otherwise be unable to afford ticket prices.

Sea Cliff Chamber Players from Sea Cliff, N.Y., are developing outreach programs for inner-city audiences and are hiring older people as musicians for works needing players outside of the regular ensemble.

Shreveport Symphony Society of Louisiana presents a matinee series of three concerts for senior community centers in Shreveport.

Strings for Schools, Inc., in Villanova, Pa., is expanding its string chamber program informal concerts and workshops to reach elementary and secondary schools and institutions for elderly and handicapped individuals.

Toledo Symphony Orchestra in Ohio is supporting concerts and educational programs in nursing homes, senior centers, and mental health centers.

OPERA-MUSICAL THEATER

Lyric Opera of Chicago, Ill., supports a String Festival which includes the production of a chamber opera and a specially prepared presentation for older and handicapped people.

Natural Heritage Trust/Artpark in Lewiston, N.Y., has expanded the number of this season's performances to 51, including a number of weekly matinees for senior citizens and youth groups.

Opera Company of Philadelphia in Pa., is broadening its scope to include educational programs, student performances, workshops, and classes for senior citizens in isolated communities in Pennsylvania, New Jersey, Delaware, and western New York.

Seattle Opera Association in Washington is expanding their outreach and education program to include older adults and those living in rural communities.

Wolf Trap Foundation in Vienna, Va., has developed a series of 12 interpretive programs conducted by American artists, designed to introduce new audiences such as senior citizens, to opera and musical theater.

PARTNERSHIP

Grand Monadnock Arts Council of Keene, N.H. is expanding their program of performances and workshop in poetry, printmaking, clay, sculpture, and creative movement to include institutionalized, elderly and handicapped people. The documentation of this process should aid other local arts agencies in developing additional programing.

PARTICIPATORY ARTS PROGRAMING

Active participation in the arts by older Americans has continued to expand because of professional arts programing. Through Endowment advocacy and financial support, professional artists are being given the opportunity to work with seniors in very special ways. The artists are becoming aware of the overwhelming sensitivity and creativity that older Americans can offer in terms of the arts. The following grantees are providing participatory arts programing for older adults.

EXPANSION ARTS

Birmingham Creative Dance in Alabama offers performances, classes, and workshops for senior citizens and emotionally handicapped youth.

Creede Repertory Theater, Inc., in Creede, Colo., offers a senior citizens drama workshop, as well as special free performances for senior and migrant workers.

The Dance Exchange in Washington, D.C., conducts movement classes in senior centers, apartment buildings, hospitals, and day care centers throughout the metropolitan area. Training teachers to work with the elderly and handicapped populations in movement is an integral part of this program. The Dance Exchange also supports an intergenerational performance group well known in the Washington area called "Dancers of the Third Age."

DeCordova and Dana Museum and Park in Lincoln, Mass., offers an outreach program in fine arts, photography, and crafts for older people in senior centers and nutrition sites. Once acquainted with the offerings of the museum, seniors are provided with transportation to the class of their choice.

Iowa Arts Council in Des Moines, Iowa, is continuing their "Arts and Older American" program, a senior citizen participatory arts program including classes and workshops, and artists-in-residence.

Madison Community Access Center, Inc., in Wisconsin, trains older Americans in video production, including instruction in production planning and the use of the portable, studio, and editing equipment.

Manchester Craftsmen's Guild in Pittsburgh, Pa., instructs inner-city elderly and handicapped individuals in ceramics, textile arts and photography.

FOLK ARTS

Department of Community Services in Jonesboro, Tenn., plans to explore the development of country music radio from its roots in traditional mountain music by tracing secular/dance music traditions from the oldest forms of stringband music to bluegrass. Concerts will present both older and younger country musicians.

Mexican American Opportunity Foundation in Monterey Park, Calif., will support a program of cultural enrichment for migrant workers and the urban poor populations using the music of the mariachi as played by expert senior mariachi players.

Monroe County Rural Heritage Alliance, Inc., of Union, W. Va., will continue their program of free classes in traditional music taught by older master traditional musicians in homes, county high schools, and senior centers.

LITERATURE

Eight fellowships have been awarded to older writers and poets including Djuna Barnes from New York, Kay Boyle from San Francisco, Sterling Brown from Washington, D.C., and Josephine Miles from Berkeley, Calif. Josephine Miles, a poet, essayist, critic, and teacher, was born in 1911. Ms. Miles is the author of over a dozen collections of poetry, most recently "To All Appearances: New and Selected Poems," published by the University of Illinois Press in 1974. Ms. Miles has received numerous literary fellowships and has served as a source of inspiration to younger writers. However, apart from poets and serious critics, her work is hardly known.

INTER-ARTS

Multiarts programs for St. Mary's Court in Washington, D.C., provides free instruction in music, drama, visual arts, and movement for the older people who reside in this low-middle income facility.

MEDIA

Council for Positive Images, Inc., in Los Angeles, Calif., is sponsoring a series of 30-minute visits with elderly artists and scholars. These senior citizens will share their visions, remembrances, reflections, and critical observations with their public through interviews.

MUSEUM

El Museo del Bario in New York City has purchased works of older painters for a permanent Puerto Rican art collection. These painters are presently represented only by their smaller works or works on paper rather than complete paintings.

The Dublin Gallery of Art in Knoxville, Tenn., is supporting an outreach public service art program for all ages at senior citizen centers and homes for handicapped and mentally retarded individuals.

The Institute for Contemporary Art in Boston, Mass., is supporting a program designed to enhance mobility training for newly blinded adults.

The Museum of Modern Art in New York City is expanding their educational programs that are conducted by graduate students in the museum and in community centers, senior citizen residencies, associations for the handicapped, and other social services organizations.

VISUAL ARTS/PHOTOGRAPHY

Andrea Gray from Carmel, Calif., is involved in producing a 1-hour documentary film on the life of Ansel Adams, one of the most important photographers of the 20th century who is almost 80 years old.

Donald Sunseri of West Glover, Vt., is involved in a program of discovering and promoting native talents in the northeastern section of Vermont. Sunseri has exhibited and lectured on the high quality of work produced by older residents, whose average age is 87 years old.

Coast Community College District in Costa Mesa, Calif., is researching and recording segments of the history of photography by videotaping interviews with six senior women photographers.

Fine Arts Museum Foundation of San Francisco, Calif., will support "San Francisco/Los Angeles, 1945–80," a photographic exhibition of approximately 60 works by Max Yavno, an important senior west coast photographer. The Yavno exhibition reflects the development and social changes in San Francisco and Los Angeles as Yavno recorded them over the last 35 years.

ITEM 26. NATIONAL ENDOWMENT FOR THE HUMANITIES

JANUARY 15, 1981.

DEAR SENATOR HEINZ: I am pleased to enclose a report summarizing major activities for or about the aging which were supported by the National Endowment for the Humanities in 1980.

It is my hope that you and your committee will find this summary of our activities and plans useful. I also hope that other readers of the report will be stimulated by it to develop other kinds of humanities projects to benefit older Americans and to increase understanding of the special problems and challenges they face.

Please let me know if we can be of any further help to your committee.

Sincerely,

JOSEPH D. DUFFEY, *Chairman.*

Enclosure.

REPORT ON ACTIVITIES AFFECTING OLDER AMERICANS IN 1980

I. INTRODUCTION

The National Endowment for the Humanities recognizes the important contributions made by older Americans to scholarship in the humanities and to the broader society. It also recognizes that our senior citizens have a special need for the enrichment which the humanities can bring to their lives, as well as for the knowledge and perspectives which the humanities provide all citizens, young and old, as they strive to make informed personal and civic choices. To these ends, NEH encourage utilization by the elderly of Endowment-supported products (such as print materials, museum exhibitions, radio and television programs) and seeks increased participation of older Americans in a wide variety of NEH-supported activities, including scholarship, formal and informal educational programs, and discussions of public policy and other vital questions in communities throughout the United States.

Some of the ways in which the aging do participate in the Endowment's programs are discussed in section II of this report.

Last year, in order to insure that older Americans have access to Endowment funds and programs, the Endowment developed and published in the Federal Register its proposed regulations under the Age Discrimination Act of 1975. As a result of this publication, comments on the proposed regulations were received and acted upon. Although the deadline for comment has now passed and the Department of Health and Human Services has approved the modified regulations, procedural changes now require Justice Department approval before the regulations become final.

In addition to several specific grants cited below, the upcoming White House Conference on the Aging prompted the development of a memorandum of understanding between NEH, NEA, the Administration on Aging, and the White House Conference on Aging, itself. Through this memorandum the agencies entered into agreement for long-term, comprehensive programs of cooperation in the area of humanities, arts, and aging.

II. PARTICIPATION BY OLDER AMERICANS IN NEH PROGRAMS

In carrying out its congressionally mandated mission of furthering the understanding and use of humanistic knowledge in the United States, NEH responds to the needs and interests in the humanities, primarily as they are expressed in unsolicited applications for specific projects. Therefore, the agency does not usually set aside fixed sums of money for work in any subject area or for particular groups. As a result, there is no single program for senior citizens using funds specifically allocated for that group; nor is there a single program within the agency to support the study of the aging process or of elderly people. Rather, both such interests can be pursued through the full range of Endowment programs depending on the project's goals and formats.

Through the regular selection process of these grant programs, NEH funds a great number of projects involving older individuals as project directors, project personnel, or consultants. One of the agency's most distinguished grantees, Dumas Malone, now 89 years old, is now nearing completion of his monumental multivolume biography of Thomas Jefferson. This comprehensive history, which was begun in 1943, won the Pulitzer Prize in 1975. Speaking at a recent ceremony marking the Endowment's 15th anniversary, Mr. Malone recalled that "* * * Some years ago a distinguished historian (Carl Becker) predicted that if anyone should be so foolhardy to attempt a comprehensive biography of Thomas Jefferson, he would enter the labyrinth and never emerge. I was in the middle of that labyrinth when I approached the Endowment, and with their help I have been slowly making my way through it ever since. I am not out yet, but, God willing, shall be soon." Mr. Malone is just one of the notable older scholars aided by the Endowment who demonstrate that age is no bar to significant achievements in the fields of the humanities.

Elder Americans without scholarly training make essential contributions to many of the Endowment's projects. For instance, projects for the creation of Native American language dictionaries and tribal histories frequently use elderly members of the tribe as consultants or informants. District 1199 Hospital Workers Union's "Bread and Roses" project made similar use of the resources provided by the elderly for a very different purpose: oral history workshops with retirees from the union were used to develop the material for a musical presentation, "Take Care." Also, retirees have served as both guides and audiences for many of the exhibits, discussion programs and conferences conducted under the "Bread and Roses" project.

In the same way, the University of Baltimore's Baltimore Neighborhood Heritage Project derived substantial historical material from interviews with elderly residents of Baltimore's highly ethnicized neighborhoods. "Baltimore Voices," derived from the interviews, has been performed over 200 times before community audiences made up more often than not of the elderly in the neighborhoods or senior centers. District 1199 and Baltimore projects are just two illustrations demonstrating how older Americans have served as both resources and audiences for many Endowment funded projects in the humanities.

All of the activities supported by NEH to increase understanding and use of the humanities among the general public reach large numbers of older Americans.

Media programs. The quality radio and television productions supported by the Endowment (e.g., Odyssey, Hard Choices, the Adams Chronicles, and the American Short Story series) are especially useful to older people, many of whom cannot or prefer not to leave their homes. NEH encourages grantees to promote the use of media productions among senior citizens and urges applicants to plan media programs with this group in mind. Specific information on media programs and any adjunct material produced is provided to all organizations working for special groups, including the elderly.

Humanities radio programing, like "A Question of Place" series on National Public Radio, serves a wide audience, including the visually handicapped, who might have limited access to the humanities in other media. For many elderly people confronting problems such as impaired vision and reduced mobility, these Endowment-funded programs provide access to information as well as a mechanism for communicating with others.

Education programs. Making use of the media productions cited above and accompanying printed materials, many institutions of higher education, including community colleges, are offering courses for credit. Some of these courses are particularly suited for those elderly students whose mobility may be limited by health or transportation problems since they do not require attendance on campus. However, all provide good opportunities for continuing a lifelong education.

The Endowment's concern with continuing education goes beyond courses tied to NEH funded media productions. For the past 2 years the Endowment conducted a continuing education initiative. This initiative included seven regional workshops, each with participants from about 25 institutions, with discussions focusing on fashioning programing to meet the needs of a variety of new audiences, including the elderly. Such conferences will doubtless result in future grants similar to that which enabled Scottsdale Community College to create a program on the culture of the Southwest targeted to newcomers to the area, often the recently retired.

Courses by newspaper. In 1980–81 the Endowment-supported Courses by Newspaper programs administered by the University of California, San Diego continued to present nontraditional college-level courses. These courses are offered to the general public nationally through the cooperation of hundreds of participating newspapers and educational institutions. A series of newspaper articles prepared by outstanding scholars serves as the basis of a course offered at local colleges and universities for those readers desirous of earning college credit. More than 450 newspapers and 300 colleges and universities cooperate regularly to bring these courses to citizens of every State, Puerto Rico, Guam, the Virgin Islands, as well as parts of Europe, Canada, New Zealand, and the Far East.

Recent Courses by Newspaper have included "Death and Dying: Challenge and Change" (1979), "The American Family in Transition" (fall 1980), and "The Nation's Health" (spring 1981), subjects of considerable and special interest to older Americans.

Other projects supported by NEH are specifically designed either to increase understanding of the special problems and challenges facing the elderly or to provide learning experiences in the humanities for older citizens. These are detailed in section III of this report. In addition, regrants on NEH funds through the State-based humanities committees have supported many locally initiated and conducted projects of these kinds, some of which are described in section IV.

III. SPECIFIC NEH GRANTS SERVING THE ELDERLY

Continuing until the fall of 1981, the Endowment's grant to the National Council on the Aging for its senior center humanities program is involving 22.5 million older Americans in the humanities through activities held at more than 800 service centers (including senior centers, nutrition sites, day care programs, and nursing homes). In addition, during 1980 the Endowment made new awards totaling over $600,000 for projects designed—as a whole or in part—to increase knowledge about aging or to provide special materials or activities for older persons. Although there is obviously a good deal of overlap, these might be divided into three categories: (1) Programs about aging and the elderly in our society and others; (2) programs for older Americans; and (3) programs using senior citizens as consultants or resource people. Examples of such programs funded in 1980 follow:

A. Programs about aging and the elderly

1. "Humanistic Approaches to Aging."—This $19,900 grant to Illinois Benedictine College enabled implementation of an interdisciplinary course on humanistic approaches to aging to be taught by a special consortium faculty. It is hoped that the course will serve as a demonstration model for other institutions.

2. "Changing Male and Female Roles and the Aging Process."—This $14,994 grant to Columbia University supports a study of the impact of changing sex roles on the aging process as it is being experienced by men and women in late 20th century America.

3. "Issues in Geriatric Care."—This $12,000 grant, jointly funded with NSF through the science, technology, and human values program, will enable a specialist at a VA hospital in Portland, Oreg., to conduct interdisciplinary research concerning judgments made by health professionals about patients' competence to make decisions about their care. Conceptual inquiry and field study in a geriatric ward will result in a paper on guidelines for judging competence in borderline cases.

4. "Cambridge Women's Oral History Project: Historical and Cultural Perspectives."—This $23,100 grant to the Cambridge Arts Council will enable a core group of teenage women to collect oral histories of senior citizens and develop a slide/tape presentation and a guidebook on "life transitions" and choices among older women.

5. "Asian Americans History Youth Project."—This $5,000 Youth Project grant to Asian Americans for community involvement will enable Asian American youth in Santa Clara County, Calif., to learn about the history of Asians in America by active participation in the writing and production of videotapes on significant events and issues, including Asian American elderly.

B. Programs for older Americans

1. "White House Conference on Aging Miniconference on the Arts, Humanities, and Older Americans."—This $30,000 grant is enabling the National Council on the Aging to hold a miniconference prior to the White House Conference on Aging to develop information and recommendations concerning the arts, humanities, and aging for inclusion in the full conference agenda.

2. "Ethnicity and Aging: A Humanistic Assessment of Public Policy."—This $30,000 grant will enable the National Center for Urban Ethnic Affairs to hold a miniconference prior to the White House Conference on Aging to explore ways to improve European-American elderly, their families and communities in articulating their particular problems and in finding solutions to them with the help of government and the private sector.

3. "The Humanities in Gerontology and Geriatric Medicine: Toward a Future Integration."—This grant for $5,086 will support two sessions at the annual meeting of the Gerontological Society on: (1) The role of the humanities in geriatric health, and (2) the role of the humanities in long-term geriatric care institutions. This grant for $49,598 will enable Wichita State University to develop and implement a continuing education program in the humanities for senior citizens and nontraditional students who have been generally overlooked by university programs nationwide.

4. "Country Roads and City Streets: On the Trails of History—People, Places, Things."—This $5,000 grant to the Ocmulgee Regional Library in Eastman, Ga., will support a project in which area youth conduct field research to discover and document sites of historic importance in five counties, and present their findings to youth and senior citizen audiences through exhibits and workshops.

C. Programs using senior citizens as resources

1. "Youth-to-Elderly Oral History Project."—This grant for $5,000 to the Salem, Mass., Youth Commission will enable Salem area youth to conduct oral history interviews with local senior citizens to gather material for both an exhibit and a radio series.

2. "United Negro College Fund Oral History Project."—This $25,000 grant to the United Negro College Fund will support an intensive 1-year oral history project to collect, transcribe, and process interviews with between 16 and 24 elderly individuals who have been important in the 35-year history of the Fund.

3. "NUX BAGA (The People) Oral History Project."—This $5,000 grant to Fort Berthold (North Dakota) Community College will support a pilot project in which youth from the Fort Berthold Indian Reservation will conduct oral history interviews with tribal elders and prepare an exhibit and workshop on the environmental, cultural, and social impacts of the flooding of the reservation's most fertile land.

4. "Personal History of Five Women (1900–1980)."—This $2,000 summer stipend to a young San Francisco State University sociologist will make it possible to interview and research the sociohistorical backgrounds of five women, all in their seventies, who, despite their varied life experiences and personalities, all display caring and commitment in their daily lives. The study will examine the experiences which contributed to these values.

5. "Bridges from the Past."—This $5,000 grant to the Bethlehem Center in Charlotte, N.C., will support a project in which local youth, predominantly black and low income, will learn about life in the early 1900's for low-income black families from small group meetings with the elderly. The youth will compile a booklet and present a program of cultural recollections.

IV. STATE PROGRAMS AND THE AGING

The State programs division of the Endowment makes grants in 50 States and in Puerto Rico and the District of Columbia to State humanities committees. These committees, in turn, respond to competitive applications from institutions and organizations within the State for humanities projects of broad benefit to the citizens of the State. In recent years the majority of the projects funded across the country have focused on issues of public policy or of contemporary concern to the society. Therefore, many projects deal with the topics of biomedical ethics, death and dying, the status of the family within the society, and with other issues of particular concern to the elderly. Like the grants made directly by the Endowment, these "regrants" fund projects in a variety of formats. The following dozen examples give some indication of the breadth of these undertakings:

1. Iowa: As part of the annual Elderhostel Cultural Festival, 20 colleges and universities in Iowa received a $9,497 grant to conduct an on-campus college experience for the elderly including humanities courses with a special focus on ethnic heritage.

2. Georgia: Fort Valley State College received a $950 grant toward a 3-day festival to increase awareness of the ways in which the history of the region is preserved in the personal skills, talents, and artifacts of local people, especially the elderly.

3. Florida: The Miami Gray Panthers received a grant of $8,450 to bring together academic humanists, health practitioners and representatives of senior citizens' organizations for an examination of age-related issues as they pertain to the humanities. Twenty meetings held at different locations in the Dade County area used films, speeches, and panel discussions as means to explore the underlying values in our treatment of the elderly.

4. Delaware: The Ingleside Retirement Apartments received a grant of $762 to conduct a program of reading and discussions guided by an academic humanist on the evolution of the American short story. The stories selected include many of those in the PBS American short story television series, and Endowment-funded project.

5. District of Columbia: The Department of Social Work of the city government received a $5,515 grant to hold a conference in which humanities scholars participated in discussions focusing on changes in health status and the social worker's role in assisting individuals to deal with these changes. The two main topics for panel discussions and workshops were teenage pregnancies and the elderly.

6. Connecticut: Mohegan Community College received a grant of $8,055 to conduct drama and poetry workshops for senior citizens and out-of-school adults. Twelve of these sessions were held at Mohegan Community College, while twenty-four were conducted at senior centers in southeast Connecticut. To give additional perspectives on the literature studies, the program also included four trips to major productions of the Hartford Stage Company and the Long Wharf Theatre in New Haven.

7. California: The Gray Panthers received a $12,817 grant to hold 10 invitational meetings and workshops to consider present-day patterns of old age and of the relationships among older adults and their children in light of history, literature, philosophy, religion, and ethics.

8. Arizona: The University of Arizona received a grant to develop a program based on materials from the National Council on Aging. The program, focusing on common family dilemmas and joys, examines selected historical events (specifically immigration in the Great Depression) which have dramatically affected the course of life in individual families.

9. Colorado: The University of Colorado received a $10,500 grant to conduct lecture/panels on the parallel developments in the humanities, sciences, and social sciences. The lecture/panels are held at a senior citizen center. Senior citizens also attend classes at the college.

10. Alabama: A grant of $913 funded a panel discussion, carried over radio, examining society's values and attitudes on aging and the origins of these. Special attention was paid to the negative self-perceptions of the aged, boredom, alcoholism, and the dissolution of the nuclear family.

11. Alaska: A grant of $3,425 to Kodiak Community College funded a pre-retirement seminar involving humanities scholars and others in examining how land issues and their resolution either encourage or discourage people of retirement age to remain in the State.

12. Indiana: A grant of $2,000 funded a museum exhibit of the work of "over 90" photographer Imogan Cunningham. A film and followup discussion lead by academic humanists focused on the creativity of the elderly.

ITEM 27. NATIONAL RAILROAD PASSENGER CORPORATION

JANUARY 16, 1981.

DEAR MR. CHAIRMAN: The National Railroad Passenger Corporation (Amtrak) holds strongly to its commitment to make rail passenger service more comfortable and economical for both elderly and handicapped travelers.

As you may know, in 1980 Amtrak began offering a 25 percent discount to senior citizens and handicapped travelers on one-way trip fares of $40 or more. The special discount does not impose holiday restrictions, round trip requirements, or limits on length of stay. The fare reduction is the largest in the transportation industry, is the simplest to use, and is the only one which applies to handicapped citizens as well as to the elderly. This program was implemented to reflect the national priority to urge citizens out of their isolation by removing both the physical barriers and the financial constraints which have often denied both groups access to the intercity transportation network.

Federal law has defined the senior citizen as being 65 years of age or older for the purpose of determining eligibility for discounts. The law has also set the definition of handicapped as persons with a physical or mental impairment which substantially limits their ability to care for themselves. A driver's license, birth certificate, or any other official document showing age is acceptable to qualify for our discount to the elderly. Cards certifying an individual as handicapped, such as those issued by the government or by groups representing handicapped persons, or a letter from a physician may be used to purchase a reduced fare ticket.

Amtrak has been directed by Congress to take all steps necessary to modify its stations to allow the elderly and handicapped accessibility to the facilities. In fiscal year 1981, Amtrak plans to expend $3.1 million in the process of complying with this requirement, adding 18 stations to the existing stations with barrier-free access.

By the close of 1981, wheelchair platform lifts will be available at 160 manned stations in 36 States across the country. These lifts will make trains more easily accessible from the low platform level for wheelchaired passengers. Amtrak is very close to the 1984 deadline for installing wheelchair lifts at all manned stations. Most of the stations currently without wheelchair lifts are either unmanned, have high-level platforms, or are equipped with wheelchair ramps.

Funds have been set aside in Amtrak's program for refurbishing old passenger cars to provide for the installation of special restrooms, accessible coach seating, and modified sleeping accommodations. All Amfleet, Turboliner, and Superliner trains are equipped with special seats and accessible restrooms.

Passengers who have special needs, such as specially prepared meals, or who require assistance boarding or leaving the train, should discuss these needs in advance with the agent at the special services desk who will coordinate their trip from beginning to end. The passenger should simply call the Amtrak toll-free number in his area and the agent will make every effort to insure the individual's comfort.

Amtrak's current services to the elderly and handicapped train travelers are described in a booklet "Access Amtrak," which is available free of charge from Amtrak, Corporate Communications, 400 North Capitol Street NW., Washington, D.C. 20001.

Thank you for your interest in this matter. We look forward to improved service to senior citizens.

Sincerely,

LAWRENCE D. GILSON,
Vice President, Government Affairs.

ITEM 28. NATIONAL SCIENCE FOUNDATION

DECEMBER 10, 1980.

DEAR MR. CHAIRMAN: Thank you for the opportunity to provide information for the annual report, "Developments in Aging," for the fiscal year 1979.

The National Science Foundation supports scientific research which, in general, does not fall within the responsibility of other agencies. The Institute on Aging in the National Institutes of Health is the primary funding agency for research dealing with the aging. Nevertheless, the National Science Foundation in its basic science programs, or in the context of more policy-oriented research programs has supported research and other activities, such as conferences, directly or indirectly related to problems of the aging.

The Directorate for Engineering and Applied Science has supported projects on policy issues related to the elderly. The Directorate for Science Education has supported programs of science for the elderly, forums on research on aging, and cosponsored with the National Institute on Aging a television series on the brain which has segments pertaining to aging.

Basic research in biology, in areas such as plant senescence, senescence of nervous systems, and developmental behaviorial problems is related to aging and continues to be funded through programs in the Directorate for Biological, Behavioral, and Social Sciences.

Enclosed are copies of project summaries and program award recommendations for some National Science Foundation projects related to aging.[1]

If you require further assistance, please let me know.

Sincerely,

HENRY C. BOURNE, Jr.,
Deputy Assistant Director for Engineering and Applied Science.

ITEM 29. OFFICE OF CONSUMER AFFAIRS

THE WHITE HOUSE,
Washington, December 31, 1980.

DEAR MR. CHAIRMAN: In response to your request, I have enclosed two copies of the summary of U.S. Office of Consumer Affairs activities during 1980 relating to the elderly.

My office is pleased to have the opportunity to contribute to the committee's annual report on aging. We are keenly aware of the needs of the elderly. In 1981 the Office plans to expand its activities to provide greater assistance to elderly consumers.

Sincerely,

ESTHER PETERSON, *Director.*

Enclosure.

REPORT OF ACTIVITIES OF THE U.S. OFFICE OF CONSUMER AFFAIRS DURING 1980 RELATING TO OLDER AMERICANS

The U.S. Office of Consumer Affairs (USOCA) serves as the staff of the Special Assistant to the President for Consumer Affairs and advises Federal agencies on consumer-related policies and programs. USOCA encourages and assists in the development of new consumer programs, makes recommendations to improve the effectiveness of Federal consumer programs, cooperates with State agencies and voluntary organizations in advancing the interests of consumers, promotes improved consumer education, coordinates consumer complaints, recommends legislation and regulations of benefit to consumers, and encourages productive dialog and interaction between industry, government, and the consumer.

Major activities have primarily focused on consumer advocacy, consumer education and information, and planning and analysis. While these activities in general are initiated on behalf of all consumers, it should be noted that the elderly consumer shares fully in the benefits of USOCA programs.

Highlighted below are major activities having the greatest impact on older Americans.

CONSUMER ISSUES

Banking and Credit

The U.S. Office of Consumer Affairs has obtained agreement from the American Bankers Association to create a National Consumer/Banker Panel to seek compromises on public policy issues affecting banker and consumer. The eight consumer members will include an advocate of the concerns of older Americans.

Financial Institutions Monetary Control and Deregulation Act of 1980

In July 1979, the Office testified in favor of provisions of this act which allows interest to be paid on checking accounts and also supported its provisions to lift the limitations on interest rates paid on savings accounts. This latter provision was of particular interest to the Gray Panthers. The bill was signed by the President on March 31, 1980.

Usury Laws

Most States limit the amount of interest which can be charged for consumer loans. USOCA has worked to prevent wholesale Federal preemption of State usury laws. High loan interest rates will hit elderly consumers in need of loans since many have fixed incomes. We are supporting creation of a joint consumer-business commission to study the issue of Federal preemption.

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[1] Retained in committee files.

Regulation B: Equal Credit Opportunity Act

USOCA is currently reviewing a proposed interpretation of the Federal Reserve Board which would require that equal points in a credit scoring system be given to income from pensions or social security. USOCA filed comments last year urging the Board to make such requirement clear to creditors. This, and a related interpretation providing for giving reasons for credit denials, are particularly important if discrimination against the elderly in the granting of credit is to be prevented.

Mortgages

A number of new mortgage instruments allowing for increases in interest over the life of the loan have been proposed since April 1979. (New proposals are still being made.) In each case, the mortgages available to the elderly will affect their ability to buy a retirement home if they require a loan to do so. USOCA reviews and comments on each to assure sufficient disclosure of terms and the widest availability of mortgage loans.

ENERGY

Utility Construction Programs

The U.S. Office of Consumer Affairs has been actively involved with the issue of whether consumers should pay for the costs of construction of utility plants before plants provide service. Utility construction programs normally take more than 10 years to complete. USOCA has taken the position that only customers who actually receive service from a plant should be required to pay for it.

With such long construction periods involved, many customers, including senior citizens, may not be customers of a utility for the duration of a construction project. Most senior citizens will not be customers for the entire useful life of a plant. Accordingly, USOCA has vigorously argued that it is inequitable to require today's customers to subsidize the cost of producing electricity for future customers.

USOCA has been involved in two cases involving this issue before the Federal Energy Regulatory Commission. In addition, it has argued this position in response to a proposed guideline issued by the Council on Wage and Price Stability.

PURPA Service Termination Standard

The Public Utility Regulatory Policies Act of 1978 (PURPA) established certain standards for the regulation of gas and electric utilities which State regulatory authorities and nonregulated utilities are required to consider. Among the standards so established is a standard regarding procedures for terminating gas and electric service. On October 19, 1979, the Department of Energy published proposed guidelines to assist State regulatory authorities and nonregulated utilities in their consideration of this standard. USOCA submitted comments on several aspects of the proposed guidelines.

A utility's termination policies and procedures are of great importance to the elderly, particularly if they live in regions which experience severe winters or summers. Rapidly rising utility rates make it increasingly difficult for older persons on fixed incomes to pay their utility bills. Furthermore, the elderly generally have a less elastic demand for heat or cooling than the general population because of greater physical infirmity. Therefore, the elderly cannot very easily reduce bills by conserving energy. Also, when heating or cooling service is disconnected for nonpayment, older consumers are more vulnerable to sickness than the general population.

The USOCA comments sought to make the Department of Energy guidelines even more responsive to the needs of the elderly. We suggested, for example, that utilities should make personal contact with an adult on the premises before terminating service, since many elderly people are confused or embarrassed by written notices, and indeed, many mailed notices are lost, stolen, or never delivered. Another example was our suggestion that consumers should have the right to initiate complaints by telephone, since it is difficult for many of the elderly and handicapped to write or visit an agency. We also recommend that consumers should have the right to arrange for deferred payment plans to pay amounts in arrears, since utility budget plans are frequently not available to consumers on fixed incomes because of strict credit requirements.

HEALTH

The U.S. Office of Consumer Affairs has done significant work in the area of medigap insurance. Working with Senate and House committee staffs, preparing congressional letters, and commenting on the enrolled bill internally, we helped to set up a voluntary certification program for medicare supplemental health insurance, to be run by the Department of Health and Human Services.

Projects in health care were highlighted in USOCA's "People Power: What Communities Are Doing to Counter Inflation." Projects focusing on the activities of elderly consumers include: A medical center owned and managed by senior citizens, an adult day care center, a hospice, prescription drug price surveys, and efforts to stop nursing home neglect.

USOCA has taken several actions in the drug area which have a greater impact on the elderly since the elderly use more drugs than any other age group: Esther Peterson persuaded 20 drug retailers and 8 suppliers to institute a price freeze for varying amounts of time (usually 3 months); the Office commented in favor of a Food and Drug Administration proposal to begin a comprehensive patient labeling program for prescription drug products; USOCA worked successfully with other consumer groups to prevent an amendment to general patent legislation which would have had the effect of prolonging the introduction of generic drug products; USOCA commented on Health Care Financing Administration's draft, "A Consumer Guide To Cutting Prescripiton Drug Costs."

With the defeat of the hospital cost containment bill, Esther Peterson testified before the Price Advisory Committee of the Council on Wage and Price Stability requesting a public monitoring system to track hospital expenditures and physician fees. High hospital bills have a devastating effect on elderly consumers living on fixed incomes.

HOUSING

One issue which is of particular interest to USOCA is the problem of displacement of people from urban dwellings. There has been a marked increase in the in-migration of middle-class homeowners and renters into many city neighborhoods. As a result, many poor, elderly, and minority owners and renters are finding themselves in the position of being bought out or "involuntarily" pushed out. Elderly residents living in neighborhoods undergoing "rehabilitation" need particular attention.

USOCA will continue to work in this and other areas of housing, mindful of the effects of all housing programs on the lives of our elderly citizens. The Office will support those legislative initiatives and Federal programs that will address the housing needs of elderly citizens, and continue to work with national and local organizations that advocate the rights of older consumers.

LIFE INSURANCE

USOCA continued efforts to promote improved disclosure of life insurance costs and benefits. (State insurance regulators are currently reviewing and testing new plans for improved disclosure to enhance consumer choice.)

TRANSPORTATION

The U.S. Office of Consumer Affairs continued efforts to obtain agreement from auto manufacturers to be bound by the decisions of consumer mediation panels seeking solutions to consumer complaints arising from car purchases and servicing of cars. Toyota joined Ford in supporting this concept for resolution of consumer complaints against franchised dealers and manufacturers. Two airline companies have indicated that they are also moving toward acceptance of this approach to resolution of complicated consumer complaints. We have advised them on methodology.

USOCA served as the lead agency for the administration with respect to reform of laws regulating household movers. Retired persons who often lack the assistance of an employer in selecting and using a mover are less able than others to move without the assistance of a professional mover. While consumer abuses in the moving industry affect all age groups, the elderly are particularly reliant on the interstate moving industry. On October 15 the President signed Public Law 96-454, the Household Goods Transportation Act, which both increases competition in the home moving industry and increases consumers remedies and the Interstate Commerce Commission's ability to enforce consumer protection rules. In addition, the bill establishes guidelines for independent informal dispute settlement bodies. In late October the ICC announced a rule to implement the new law. USOCA suggested several improvements in those rules.

The Office is reviewing a proposal submitted by the National Council on the Aging to establish an automotive safety maintenance and repair consumer education program for the elderly. Increasing consumer awareness among elderly persons regarding consumer rights in safe automotive maintenance and repair will have a significant effect on reducing the excessive number of automotive repair "rip-offs" that occur daily.

USOCA serves on the Inspection, Maintenance, and Repair Interagency Coordinating Committee Task Force (IMR-ICC) which is intended to provide a more coordinated effort among Federal, State, and local governments, automotive industry, and consumer organizations concerned with improving the auto repair process in this country. Toward this end, USOCA has assumed responsibility for cochairing, along with the Federal Trade Commission, a work group that will evaluate the efficacy of automotive consumer dispute resolution mechanisms. These resolution mechanisms often serve as a viable means of addressing automotive repair disputes.

The Office submitted written testimony before the Senate Judiciary Committee of the California State Legislature outlining some of the major problems associated with automotive repair. In light of the potential high costs of auto repair to consumers and particularly to those living on fixed incomes, the testimony emphasized the need to provide consumers with information that will enable them to evaluate the necessity, costs, and quality of repairs performed on their automobiles.

USOCA has worked with the National Highway Traffic and Safety Administration in their continued efforts to develop meaningful automotive safety and maintenance information to consumers that will assist them in making an informed decision regarding the purchase of a new car. It is anticipated that the information will facilitate comparison shopping in the purchase of a new car.

OUTREACH

Conferences and Technical Assistance

Besides providing information on an individual basis, USOCA has participated in national, regional, and State conferences and workshops designed to address issues affecting low-income and elderly consumers. In addition to providing materials and information regarding possible funding sources and technical assistance, USOCA has continued to alert these groups to proposed legislation, regulations and policies that may impact on them.

USOCA cosponsored with Howard University and the D.C. Office of Consumer Protection a low-income consumer self-help conference July 9–11, 1980. The conference attracted over 800 community leaders, consumer advocates, educators, and representatives from elderly consumer organizations. The conference was the forum for the release of "People Power: What Communities Are Doing To Counter Inflation." Many of the projects highlighted in "People Power" were designed to help elderly consumers cope more effectively with inflation. Many of the people who spearheaded projects for the elderly conducted practical workshops during the conference.

USOCA is planning to cosponsor a low-income consumer conference in 1981. The conference will be cosponsored with Howard University and the D.C. Office of Consumer Protection. The issues to be addressed will be of interest to and impact on elderly consumers: housing, health care, energy, transportation, and food. Organizations representing elderly consumers will be invited to participate.

The Office is talking with representatives from elderly consumer organizations about the publication of a "Guide to Successful Elderly Consumer Projects." Since the elderly, living on fixed incomes are hit hardest by high inflation, "Elderly People Power" would significantly assist by alerting them to inflation fighting alternatives in the areas of health care, food, housing, and energy.

During the spring of 1981, the USOCA plans to compile a bibliography of consumer information publications produced by State, county, and city government consumer offices. Many of the publications that will be listed will be of interest to elderly consumers.

USOCA assisted the National Public Law Training Center in creating a model agenda for training educators of the elderly, with respect to the insurance needs of older Americans. The Center plans to began training educators in 1981.

WHITE HOUSE CONFERENCE ON AGING

As a member of the National Advisory Committee on the 1981 White House Conference on Aging, Esther Peterson has worked with the committee and conference staff in planning preconference activities and for the conference itself. Mrs. Peterson is chairman of the Subcommittee on the National Meeting and a member of Executive Committee, Issues Subcommittee, Private Sector Subcommittee, and Technical Committee on the Economy.

Mrs. Peterson has discussed the conference in speeches and articles and has urged consumers to participate in community forums, State conferences, and hearings which are designed to identify needs and concerns of the elderly and make recommendations to the national conference. USOCA provided the conference staff with a summary of Federal activities affecting the elderly in credit, housing, health care, and energy. Recommendations were also made for future consumer activities that the conference may want to address.

The USOCA is cosponsoring a White House Conference on Aging Mini-Conference on the Elderly Consumer with the American Association of Retired Persons/National Retired Teachers Association. The conference is scheduled for January 29–30, 1981 will bring together elderly consumers and professionals working in the field of aging. Those attending will identify specific consumer issues of importance to the elderly and formulate recommendations for addressing these issues.

INFORMATION AND EDUCATION

"Consumer Action Update," USOCA's twice-monthly newsletter carries articles of general interest to consumers. Many of the articles have discussed proposed legislation, guidelines, and issues that are of interest to and impacting on elderly consumers.

USOCA also publishes a weekly news column, "Dear Consumer." The following columns dealt with issues of concern to the elderly:

"The Last Consumer Purchase" (funerals).
"Elderly Consumers Must Protect Themselves" (ripoffs).
"White House Conference on Aging."
"Organizations Serving the Elderly."

Also during 1980, USOCA distributed two major publications which provide useful information to the elderly.

The "Consumer's Resource Handbook" contains a section on aging and refers to other sections in the "Handbook" of interest to the elderly such as health care, social security, and veterans' affairs. The State and local directory section of the "Handbook" lists government offices responsible for coordinating services for the elderly. Approximately 2 million copies were distributed in 1980.

In July 1980, USOCA also released "People Power: What Communities Are Doing to Counter Inflation," featuring case studies of self-help projects throughout the country aimed at reducing expenditures for food, housing, energy and health care, which are of special concern to those on fixed incomes, including many elderly people. Activities described will serve as models for groups wanting to undertake similar pursuits in their own communities. Many of the projects are designed to help seniors cope more effectively with rising costs. From special nutrition programs and grocery stores for the elderly to home repair services and health care projects for older adults, "People Power" provides practical suggestions for those interested in developing similar programs in their communities while outlining the tools needed and generating the enthusiasm to get started. "People Power" was distributed to a wide variety of senior citizen organizations and clubs. The National Council of Senior Citizens provided us with a mailing of over 5,000 senior affiliates.

USOCA sponsored "National Consumer Education Week" in October 1980 in order to bring national attention to current consumer education programs and to point to the need for strengthened programs. Activities included community classes, workshops, exhibits, and displays. Many of these activities dealt with issues of interest to the elderly, the special problems they face as consumers and the need to be informed.

USOCA has been particularly concerned with the impact of inflation on consumers, and publishes the "National Consumer Buying Alert" to provide useful information on saving money on food, energy, housing, and health care. The elderly are especially hard hit by inflation and can benefit from the tips and other information published in the "Buying Alert." Approximately 40,000 copies of the 2-page report are distributed each month.

LOCAL INFORMATION SYSTEMS

A major cause of inflation in consumer prices is what economists call an "imperfect" market—consumers do not or cannot obtain relative cost and quality information on competing providers. In service areas, consumers often lack the technical competence—in auto and home maintenance, health care, or appliance repair, for example—to make cost and quality comparisons. Even with an adequate technical background, gathering the necessary information is too time-consuming in most cases to be practical for individuals. Many products, in contrast to services, are distributed and regulated nationally; however, studies show that there is wide variation within local markets among prices for virtually identical products and, moreover, that consumers are substantially ignorant of these variations. Fixed- and low-income consumers, like many of the elderly, are particularly victimized by imperfect markets which often cause them to pay inordinate prices for poor quality services such as home maintenance and repair.

USOCA has proposed legislation to demonstrate that better consumer information—as an alternative to regulation—can combat inflation and increase productivity in consumer goods and services. This bill would authorize a small grant program to provide consumers with comparative cost and quality information on such products and services as prescription drugs, food, auto repair, and home maintenance. The program would make available presently nonexistent funding—on a matching basis—for development of local consumer information systems to gather and disseminate the information.

INTRAGOVERNMENTAL ACTIVITIES

Interagency Committees

USOCA was represented on the following interagency committees which have special impact on the elderly:

Administration on Aging Interdepartmental Task Force on Information and Referral which assesses the Federal information and referral resources that exists and develops plans for improving and coordinating resources.

Federal Interagency Committee on International Year of Disabled Persons is responsible for planning activities for the year. The activities include: Promoting national and international efforts to provide disabled persons with proper assistance, training, care and guidance; making available opportunities for suitable work; and insuring their full integration in society.

Congressional Black Caucus "Brain Trust" on the Elderly. Among other things, the Brain Trust assisted the Caucus in developing legislation to benefit minority and poor elderly citizens.

Executive Order 12160

President Carter issued Executive Order 12160 on September 26, 1979, entitled, "Providing for Enhancement and Coordination of Federal Consumer Programs." The order established governmentwide standards and imposed specific requirements that each Federal agency must meet in order to assure that government better serves all consumer needs. Over 40 Federal departments and agencies have established consumer programs.

The order addressed the problems of citizens in achieving adequate participation in government decisionmaking processes. For example, agencies are required to develop informational materials to inform consumers about their procedures for participation. Elderly consumers have been identified as a constituent group which should be reached with information. Under the order agencies must evaluate their present information materials and methods of distribution to determine if groups such as the elderly are being reached most effectively.

Consumer Complaints

National consumer education week.—In conjunction with national consumer education week USOCA sponsored a consumer education fair entitled "You and the Federal Government: A Special Consumer Affair." The fair was held on the

Mall under a yellow and striped tent. Each of the 35 participating Federal agencies set up booths staffed with persons who could provide the visitors with information about their own agencies' responsibilities, functions, and consumer programs. Because USOCA recognizes that the elderly may not be fully aware of the many Federal services and programs available to them, a special effort was made to encourage senior citizen groups to attend.

Consumer complaints.—A large number of consumer complaints received by the Federal, executive, and legislative branches are from senior citizens. USOCA encourages consumers to send their individual complaints directly to the appropriate office for assistance in complaint resolution. The Office feels that it has a responsibility to help consumers locate these appropriate offices and to encourage these offices to handle complaints in a prompt efficient manner. In this regard, USOCA is updating and revising its "Consumer Resource Handbook." The focus is on providing information in a more readily accessible manner. The "Handbook" will contain a special section on consumer programs designed to help the elderly and other special interest groups. It will also contain detailed information on how and where to complain.

USOCA held a Constituent Resource Exposition to help congressional staff people more effectively work toward resolving their constituents' consumer problems. Over 1,500 persons attended the first Expo. A second Expo is planned for early spring of 1981.

The Office made site visits to over 35 Federal agencies providing technical information on how to improve their complaint systems. During these visits special emphasis was placed on the special needs of the elderly. Additionally, USOCA sponsored quarterly meetings for Federal agency complaint handling officials on subjects of common concern. The most recent meeting dealt with toll-free telephone numbers, a Federal service that can be especially beneficial to those on fixed incomes.

The "Consumer Resource Handbook" suggests as one source of complaint resolution that consumers bring their problems to the attention of State and local protection offices. USOCA began a series of training sessions on substantive issues for State and local complaint handlers. The first session dealt with credit. A future session will deal with mail orders. Both are areas in which the elderly are particularly vulnerable.

USOCA is developing a directory of business complaint offices which will be distributed to congressional offices, Federal agencies, State and local consumer protection offices, and voluntary groups. This should enhance the complaint-handling functions of these offices. A similar directory is being prepared for distribution to consumers. This should aid all consumers, especially the elderly, in quickly resolving their consumer problems that do not involve violations of law. USOCA is also developing a series of consumer communiques that will deal with major consumer concerns. Problems that are particularly troublesome to the elderly will be addressed.

ITEM 30. PENSION BENEFIT GUARANTY CORPORATION

JANUARY 16, 1981.

DEAR SENATOR CHILES: I am writing in response to your and Senator Domenici's joint request for information on our programs which affect the elderly.

Title IV of the Employee Retirement Income Security Act of 1974 (ERISA) established the Pension Benefit Guaranty Corporation (PBGC) to administer an insurance program covering most private, tax-qualified, defined benefit pension plans. Through this program, PBGC ensures that participants in covered plans will receive the retirement benefits which they have been promised and to which they are entitled, subject to certain limitations specified in ERISA.

The most significant development affecting our programs in the past fiscal year took place on September 26, 1980, when President Carter signed the Multiemployer Pension Plan Amendments Act of 1980 (the Multiemployer Act) into law. This new law, drafted with PBGC's assistance, made major changes in the plan termination insurance program.

ERISA requires PBGC to provide insurance protection for all covered single employer plans which terminated on or after September 2, 1974, the date of enactment of ERISA. However, prior to the enactment of the Multiemployer Act, ERISA allowed PBGC to use its discretion in covering multiemployer plans which terminated before January 1, 1978, and which satisfied certain specified conditions. Mandatory coverage for terminating multiemployer plans was originally deferred until January 1, 1978, to allow additional study of the necessity for and appropriate structure of a mandatory multiemployer plan termination insurance program. (Through a series of amendments to ERISA, the Congress ultimately postponed the mandatory coverage date until August 1, 1980.) In both the single employer and multiemployer plan insurance programs, as originally designed, the event which triggered the application of our guarantees was the termination of the plan.

As early as 1977 PBGC's research and experience with plan terminations indicated that the multiemployer plan insurance program needed substantial restructuring if it was to be effective and financially sound. We found that, rather than encouraging the continuation and maintenance of private pension plans, which was a major purpose of title IV, the original multiemployer plan insurance program could actually have made the termination of a covered plan more attractive than its continuation. Our studies also indicated that the potential costs of the program could range as high as several billion dollars, an amount vastly greater than our projected financial capabilities.

The Congress responded to these problems by passing the Multiemployer Act, which created an entirely new program of multiemployer plan insurance. This new program contains a set of interrelated features which are designed to promote the successful maintenance of existing plans and to discourage plan terminations.

A key element of the Multiemployer Act is to change the insurable event from the termination of a covered plan to the inability of the plan to pay benefits when due. Whether or not the plan has been terminated, PBGC will provide financial assistance to an insolvent multiemployer plan in order to enable the plan to pay guaranteed benefits. The underlying philosophy of this program is that the best way to guarantee the payment of benefits to plan participants is to ensure the continuation of the plans which provide for these benefits.

PBGC is constantly seeking ways to improve its operating procedures in order to minimize the inconvenience which a plan termination can cause to plan sponsors and plan participants. In fiscal year 1980 we instituted two new procedures and proposed a third, which should be of particular interest to elderly plan participants. The first of these is a process which we call the SHIP (special handling of insufficient plans) transfer. This is an internal procedure, initiated in October 1979, which is designed to expedite our assumption of trusteeship for certain plans which do not possess sufficient assets to pay out at least those benefits which we guarantee. By utilizing the SHIP transfer, we are able to minimize any interruptions in benefit payments which might result from the insufficient funding of a terminated plan.

PBGC has also recently implemented an interagency agreement with the Internal Revenue Service (IRS) whereby we may obtain current addresses for participants of terminated plans who are vested, become eligible to receive benefit payments, and for whom neither PBGC nor the plan administrator (for sufficient plans) has a current address. This new procedure will facilitate the receipt by elderly people of their retirement benefits.

PBGC is also working on a regulation which concerns the allocation of residual plan assets. When PBGC receives notice of the termination of a plan covered by our insurance programs, we review the submitted materials to determine whether the plan has sufficient assets to pay out all guaranteed benefits. If the plan is sufficiently funded, we authorize the plan administrator to distribute the assets to the plan participants. Occasionally, the plan administrator may satisfy all liabilities of the plan to participants and their beneficiaries, and still have assets available for distribution. In such a case, ERISA provides that the residual assets may be distributed to the contributing employer(s) if the distribution is not contrary to any law, and if the plan provides for such a distribution to the employer(s). However, ERISA also requires that any residual assets attributable to employee contributions should be equitably distributed to the employees who made those contributions or to their beneficiaries. PBGC has proposed a regulation which prescribes procedures for properly allocating and distributing such residual assets. We are presently preparing a final regulation based in part on the public comments which we received on the proposal.

With regard to the actual operation of the plan termination insurance program, as of September 30, 1980, PBGC was trustee of approximately 501 plans covering approximately 48,164 vested participants and beneficiaries. Under these plans, PBGC pays $2,942,961 in monthly benefits to 23,093 individuals. In the absenc of PBGC many of these people might not have received any pension benefits at all

Five of the plans under PBGC trusteeship are multiemployer plans, where PBGC exercised its discretion to guarantee benefits. We currently have 21 additional multiemployer plan termination requests under review.

Finally, ERISA requires PBGC to provide advice and assistance to individuals regarding the establishment of individual retirement accounts (IRA's), and the desirability, in particular cases, of transferring an employee's interest in a qualified retirement plan to such an account upon that person's separation from service with an employer. In fiscal year 1980 we issued an updated booklet on this subject.

Any elderly person may write to Ondrea Gill, Chief, Branch of Coverage and Classification, PBGC, Room 5314, 2020 K Street NW., Washington, D.C. 20006, or may call Ms. Gill at (202) 254-4817, for information on pension protection under our insurance programs.

We hope this information is helpful to you.

Sincerely,

Robert E. Nagle,
Executive Director.

ITEM 31. POSTAL SERVICE

January 12, 1981.

Dear Mr. Chairman: This responds to former Chairman Chiles' letters of October 30 and November 26, 1980, requesting information on Postal Service programs affecting the Nation's elderly.

The most significant postal contribution to senior citizens continues to be the existence of an effective, reliable universal postal system, one which operates with the needs of the people it serves in mind. Without such a system enabling the aged and infirm to carry on their family, social, and business activities, the daily lives of millions of Americans would be less enjoyable.

Special efforts are taken by the Postal Service to make the mails easily accessible to the elderly. One such effort is the stamps by mail program. Now in its ninth year of operation, this program enables the elderly to order stamps and stamped envelopes with postage-paid forms. By enclosing a check, including a 40-cent handling fee, the customer receives the order by mail within 3 days. Another service which helps the elderly and others who find it difficult to get to the post office is the consumer service card program, which allows customers to handle problems by mail. Furnished by mail carriers, these cards alert Postal Service headquarters, as well as the local post offices, to customer complaints or requests concerning mail delivery or other services.

In seeking to prevent the mails from being used by unscrupulous operators, the Postal Service performs its second most important service to the elderly. Because they live alone and often have a reduced ability to protect themselves, senior citizens are often perceived to be easy targets by those who seek to use the mails to carry out fraudulent schemes. There are several types of fraudulent promotions, including work-at-home, medical, investment, and insurance schemes, which by their nature tend to focus on senior citizens. Since most elderly Americans live on fixed incomes, senior citizens are most severely hurt by these schemes. Brief summaries of some of the more common schemes which prey upon the elderly are enclosed.

In order to help prevent schemes such as these from succeeding, the Postal Service in 1979 implemented a consumer protection program. Specially trained postal inspectors from the Postal Inspection Service, assigned to major metropolitan areas, are responsible for working with the media, consumer protection groups, investigative agencies, and community groups such as the American Association of Retired Persons to alert the elderly and other consumers to the dangers of fraudulent promotions.

Despite the existence of such preventive efforts, the number and variety of mail fraud schemes insure that some people will continue to become victims of unscrupulous promotions. To deal with this, the Postal Service utilizes two important laws. One of these, the criminal mail fraud statute, 18 U.S.C. § 1341, is the oldest and perhaps the most important consumer protection law. It provides penalties of up to 5 years in prison and a $1,000 fine for the use of the mails to further any fraudulent scheme. The civil false representation statute enables the Postal Service, after a hearing, to stop the delivery of mail to an address found to be used for a "scheme or device for obtaining money or property through the means of false representations." 39 U.S.C. § 3005. Pending action on the mail stop order, the Postal Service is authorized to go to court to get a temporary restraining order against a person suspected of a violation. The stop order can be an effective way to put some fraudulent schemes out of business short of criminal prosecution.

In addition to protecting the economic well-being of the elderly, the Postal Service continues to help preserve their physical well-being through the "Postal Alert" or "Operation Alert" program. Under this program, which consists of a partnership effort between the Postal Service and local community groups or agencies, letter carriers keep a special watch on mail delivery boxes marked with a bright red or orange sticker given to customers registered in the program. If mail is not picked up from the mailbox in a reasonable time, the Postal Service notifies the participating civic group which then calls a friend or relative who has agreed to follow up in the event of such a warning sign.

In conclusion, I would like to stress again the Postal Service's commitment to helping the Nation's senior citizens. I hope they will continue to take advantage of the special programs we have developed for their benefit. In particular, I hope the elderly, as well as all consumers, will carefully evaluate an offer before purchasing a product or service by mail. If they feel that they have become a victim of a fraud carried out through the mails, they should immediately contact a responsible postal employee. We are here to help them and will assist them in every way possible.

Sincerely,

WILLIAM F. BOLGER.

Enclosure.

DESCRIPTION OF FRAUDULENT SCHEMES

INVESTMENT SCHEMES

Fraudulent schemes soliciting investments in franchises, distributorships, coins, gems, stock, and land have a severe effect on senior citizens seeking to protect their savings from rising inflation. One swindle, typical of investment schemes, was carried out by a Missouri corporation doing business under the name of Progressive Farmers Association (PFA). The stated purpose of the organization was to raise working capital for a new type of cooperative which would bring farmers and consumers together, eliminate the middleman, and result in lower food prices. Six thousand individuals, the majority of whom were retired or semiretired farmers, invested $12 million in PFA before it filed for bankruptcy in 1977. After a 10-month trial, the founder of the corporation and 12 other defendants were found guilty of 175 counts of mail fraud and other violations in August 1980.

INSURANCE SCHEMES

The exploitation of the fears of the elderly with regard to health insurance is another area of concern for the Postal Service. The perpetrators of one such scheme, who were recently successfully prosecuted, defrauded 100 elderly women in Massachusetts and Connecticut. They did this by overcharging for insurance premiums, falsifying health histories, selling life insurance under the pretext of health insurance and duplicating insurance coverage. In one case, maternity insurance was sold to a 93-year-old woman. Some of the victims, who ranged in age from 64 to 95, were paying between $6,000 and $9,000 a year in insurance premiums.

MEDICAL FRAUD

Faced with the ailments of advancing age and rising medical costs, many of the Nation's senior citizens become susceptible to medical quackery schemes. These schemes typically involve allegations that a proffered product can cure such conditions as arthritis, cancer, baldness, obesity, prostatic hypertrophy, sexual dysfunction, or some other degenerative condition. Such false claims have caused the Postal Inspection Service to take action to end approximately 130 medical promotions in the past year.

WORK-AT HOME SCHEMES

With prices consistently on the rise, many older citizens who live on fixed incomes are attempting to augment their incomes by seeking part-time work. Unfortunately, many are attracted to fraudulent work-at-home schemes. For an initial application fee, victims are assured they will be able to earn great sums of money by stuffing envelopes at home or making some simple product, which the promoter promises to purchase. Naturally, once the initial fee is sent, victims never hear from the promoter.

In June 1980, the Postal Service issued a brochure designed to warn people not to get involved in work-at-home schemes. This pamphlet enlists the aid of potential victims by asking consumers to notify the Inspection Service of any suspicious advertisements. To date, approximately 150 responses are being received each week. Hundreds of such schemes have been put out of business through false representation orders or consent agreements.

ITEM 32. RAILROAD RETIREMENT BOARD

JANUARY 6, 1981.

DEAR MR. CHAIRMAN: In response to your letters of October 30, 1980, and November 26, 1980, I am pleased to enclose a statement summarizing major activities of the U.S. Railroad Retirement Board on aging during fiscal 1980. I have also included information on significant legal decisions affecting the elderly under the Board's programs.

I look forward to your committee's 1980 report on developments in aging.

Sincerely yours,

R. F. BUTLER,
Secretary, for the Board.

Enclosures.

U.S. RAILROAD RETIREMENT BOARD

The U.S. Railroad Retirement Board is the Federal agency that administers a comprehensive social insurance and staff retirement system for railroad workers and their families, separate from, but closely coordinated with, the social security system. Programs administered by the Board include the following: (1) old-age, survivor and disability benefits under the Railroad Retirement Act; and (2) unemployment and sickness insurance benefits under the Railroad Unemployment Insurance Act. The Board also performs certain administrative services under the Federal health insurance (medicare) program with respect to aged and disabled railroad workers and eligible members of their families. In addition, the Board has administrative responsibility for certain employee protection measures provided by other Federal railroad legislation, such as the Regional Rail Reorganization Act, the Milwaukee Railroad Restructuring Act and the Rock Island Railroad Transition and Employee Assistance Act.

BENEFITS AND BENEFICIARIES

During fiscal 1980, benefit payments under the railroad retirement and railroad unemployment insurance programs totaled $4.9 billion. Retirement and survivor benefit payments amounted to $4.7 billion, an increase of $456 million over the same period one year earlier. Unemployment and sickness benefit payments totaled $212.3 million, an increase of $70.3 million from the preceding fiscal year.

The number of beneficiaries on the retirement-survivor rolls on September 30, 1980 totaled 1,006,000. The vast majority (80 percent) were age 65 or older. At the end of the fiscal year, 451,000 retired employees were being paid a regular annuity averaging $516, about $64 higher than a year earlier. In addition, 188,000 of these employees were being paid a supplemental railroad retirement annuity averaging $53. Nearly 234,000 spouses of retired employees were receiving an average annuity of $236 at the end of fiscal 1980. Of the 330,000 survivors on the rolls, over 290,000 were aged widow(er)s receiving an average annuity of $361. Some 866,000 individuals who were receiving or were eligible to receive monthly benefits under the Railroad Retirement Act were covered by hospital insurance under the medicare program at the end of fiscal 1980. Of these, 848,000 (98 percent) were also enrolled for supplemental medical insurance.

Unemployment and sickness benefits under the Railroad Unemployment Insurance Act were paid to 178,000 railroad employees during the fiscal year. However, only about $0.7 million (less than 1 percent) of the benefits went to individuals age 65 or older.

RAILROAD RETIREMENT LEGISLATION

A primary goal of the Board during recent years has been the passage of legislation which would insure the long-range actuarial soundness of the railroad retirement system.

Actuarial valuations of the railroad retirement system in 1976 and 1979 indicated long-term financing problems, as well as cash-flow problems in the 1980's. Recent projections, taking into account current economic conditions, indicate that the system faces cashflow problems in 1983 unless corrective legislation is enacted in the meantime.

The Board has thoroughly documented these financial conditions and carried on extensive educational activities so as to make all of the concerned parties—railway management, labor, Congress and the administration—fully aware of the extent of the system's financial problems and the necessity for resolving them within certain time frames. In order to expedite legislative assistance, the Board, which is headquartered in Chicago, Ill., established a legislative counsel's office in Washington, D.C., during 1979.

President Carter signed into law in December 1980 a bill directing railroad management and labor representatives to present joint recommendations to Congress for resolving the railroad retirement system's financing problems. Section 2 of the bill H.R. 8195 provides that "No later than March 1, 1981, representatives of employees and representatives of carriers, acting through a group designated by them, shall submit to the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Interstate and Foreign Commerce a report containing their joint recommendations for further restructuring of the railroad retirement system in a manner which will assure the long-term actuarial soundness of such system."

The bill also extends—into 1981 a schedule of cost-of-living increases payable on July 1, which are equal to 32.5 percent of the annual increase in the Consumer Price Index. This increase is applied to the tier II portion of employee and spouse annuities. The tier I portion, which is the equivalent of a social security benefit, and both tiers of survivor annuities increase automatically by 100 percent of annual increases in the Consumer Price Index, without legislation.

MAJOR RAILROAD RETIREMENT COURT DECISIONS

A December 1980 Supreme Court decision in a class-action suit, *U.S. Railroad Retirement Board* v. *Fritz*, upheld certain dual benefit provisions of the 1974 Railroad Retirement Act. The act's dual benefit vesting requirements, which have been in effect since January 1975, consequently remain unchanged. This class-action suit had sought revisions in the vesting requirements so as to provide additional benefits to some of the persons with coverage under both the railroad retirement and social security systems.

The 1974 act coordinated railroad retirement and social security benefit payments so as to eliminate certain duplications, or windfalls, allowed under previous law. However, the act provides a dual benefit windfall payment for those retired before 1975, and for future retirees who were qualified for both benefits before 1975 and meet certain vesting requirements. These vesting requirements call for (1) rail service in 1974, (2) 25 years of rail service by the end of 1974, (3) a current connection with the rail industry in 1974 or at retirement, or (4) being insured for dual benefits before leaving the rail industry prior to 1974.

The class-action suit had maintained that dual benefit windfall payments should be provided for future retirees qualified for both benefits before 1975, without regard to the additional vesting requirements.

The case of *Gebbie et al.* v. *Railroad Retirement Board* was brought before the U.S. Court of Appeals for the Seventh Circuit on a petition for review of a decision by the Board denying petitioners dual benefit windfall payments under the Railroad Retirement Act of 1974.

The plaintiffs, who are retired railroad employees, began receiving auxiliary benefits under the Social Security Act in 1977, in accordance with the 1977 *Califano* v. *Goldfarb* Supreme Court decision and related cases, which held the dependency requirement for widowers' and male spouses' benefits to be unconstitutional. The Board ruled that they were not also entitled to dual benefit windfall payments because nondependent widowers and husbands were not entitled to social security benefits as of December 31, 1974, which was one of the requirements for windfall payments.

In September 1980, the Court reversed the Board's decision and held that the Board had misinterpreted the Railroad Retirement Act in denying the claimed benefits to the petitioners. The case has been submitted to the Solicitor General for a determination as to whether a Petition for a Writ of Certiorari should be filed with the Supreme Court of the United States.

INFORMATIONAL PROGRAMS

Informational conferences for railroad labor union officials are an integral part of the Board's public information program. At these conferences, Board representatives describe and discuss the benefits available under all the Board's programs. Through these conferences, the Board saves the thousands of manhours which would otherwise be required to explain the Board's programs on an individual basis.

Seminars for railroad executives and managers are also conducted by the Board. These meetings are designed to facilitate communications and cooperation between railroads and the Board, as well as acquaint railroad officials with the Board and its programs. At these meetings, Board representatives review the Board's benefit programs, administration and financing, with special attention devoted to those areas in which both the Board and the railroads gain from better coordination.

ARTICLES

The Board's periodical, The RRB Quarterly Review, regularly publishes statistical information and articles on retired employees, their spouses and survivors. During fiscal 1980, the following articles relating to aging were published in the periodical: "Five-Year Experience Under 60/30 [Retirement] Provisions"; "Retirement and Survivor Benefit Operations"; "Legislative and Administrative Developments"; "A Brief Review of 1978-79 [Financial Operations]"; "Legal Rulings"; "Ages of Survivor Annuitants"; and "Characteristics of Employee and Spouse Annuities."

BOARD ASSISTANCE IN UNIVERSITY HEALTH STUDIES

During fiscal 1980, the Board compiled data from its records for a Harvard Medical School research study, funded by the Environmental Protection Agency, on the health effects of diesel exhaust emissions. The Board has also rendered assistance, since 1957, to an ongoing study on heart disease conducted by the University of Minnesota School of Public Health.

ADMINISTRATIVE IMPROVEMENTS

The Board has begun a benefit accuracy study to increase efficiency and improve service to the railroad public by identifying and correcting recurring claims processing problems. Also, the Board and the Treasury Department began processing nonreceipt of check reports and photocopy requests by a magnetic tape exchange, so as to expedite payment of replacement checks in many cases.

The Board has instituted various internal administrative improvements to increase efficiency. In December 1979, the Board initiated a management improvement study to promote more efficient, effective and economic operations of the agency. By implementing some of the recommendations in the study, the backlog of retirement and survivor appeals cases on hand declined from 312 to 224 over the fiscal year, and organizational changes were made in computer operations. The Board also increased its internal audit staff and developed a comprehensive audit plan.

An automated folder control system was put into operation in 1979, with a marked reduction in the number of misplaced folders and related processing problems. Improvements in computer facilities and operations include a back-up computer system, a new direct access storage system and a formal implementation plan identifying security measures the Board can take to reduce the vulnerabilities of its computer records system at a minimum cost.

Other improvements during the 1980 fiscal year included (1) significant progress in reviewing and revising the Board's regulations into clear and simple English, (2) reducing the public information reporting burden by approximately 4,000 hours and (3) the initiation of a pre-retirement counseling program for the Board's own employees.

ITEM 33. SMALL BUSINESS ADMINISTRATION

JANUARY 16, 1981.

DEAR MR. CHAIRMAN: This is in reply to Senator Chiles' request for information on programs for the aging for the Senate Special Committee on Aging's annual report, "Developments in Aging."

During the past year, the Small Business Administration has been very active in promoting programs of interest to the Aging.

In September 1980, our Offices of Advocacy, Management Assistance, and Financial Assistance sponsored a "Conference on Small Business and Senior Citizens: Entrepreneurship, Consulting, and Employment." A copy of the conference announcement is enclosed.[1]

In October 1980, the Small Business Administration Hartford, Conn. District Office joined with the Connecticut State Department of Economic Development, the Connecticut Business and Industry Association, the Chamber of Commerce regional and local organizations, and the State of Connecticut Job Service agencies in supporting the State of Connecticut Department on Aging sponsored "Employment Information Seminar on Older Workers." This seminar was scheduled to assist small business employers to identify, recruit, and effectively utilize abilities of workers over age 55. A copy of the announcement of the seminar is enclosed.[1]

Additionally, SBA's involvement with the problems of the aging has been strengthened by our designating a member of our staff to represent the Small Business Administration on the Interdepartmental Task Force on Statistics on Aging and to assist the Administration on Aging to update their "Inventory on Federal Statistical Programs Relating to Older Persons." We have also designated our representative on the Interdepartmental Task Force to serve as the SBA liaison to the White House Conference on Aging.

The Civil Rights Compliance Division of the Small Business Administration's Office of Equal Employment Opportunity and Compliance assures nondiscrimination on the part of SBA program offices as well as recipients of financial assistance. Complaints of discrimination under the Age Discrimination Act are sent to the Federal Mediation and Conciliation Service for mediation prior to investigation of the complaints.

SBA continues to actively enforce regulation B (12 CFR 202) of the Federal Reserve System and its own requirements under the Equal Credit Opportunity Act, as amended. During fiscal year 1980, SBA monitored 27,619 recipients for nondiscrimination, including compliance with the Equal Credit Opportunity Act's prohibition against discrimination on the basis of age.

In 1964, the Small Business Administration established a volunteer program called the Service Corps of Retired Executives (SCORE). The objective of this program is to provide management assistance service to the small business community. SCORE is comprised of volunteers retired from the active business world who have had a lifetime of business experience and are willing to share this knowledge and experience with others. SCORE provides a business person-to-business person advisory relationship. In addition to the invaluable service that is derived by the small business owner/operator, there is an added benefit to the volunteers. SCORE members know that their aid is needed and their participation provides the retired volunteers with a sense of satisfaction for contributing his or her knowledge to help others.

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[1] Retained in committee files.

SCORE volunteers have counseled over 900,000 small businesses since 1964 and the organization has grown from the initial 1,000 members to its current membership level of 8,000 organized into 380 chapters located throughout the United States. In fiscal year 1980 SCORE volunteers counseled over 150,000 small business owner/operators.

Sincerely,

A. VERNON WEAVER, *Administrator.*

ITEM 34. VETERANS ADMINISTRATION

JANUARY 14, 1981.

DEAR MR. CHAIRMAN: In response to your request of October 30, 1980, I am pleased to forward the enclosed report on the Veterans Administration activities relating to developments in aging for the year 1980.

As you know, this agency has a significant interest in our aging population. Over 2.9 million of the more than 30 million veterans in this country are 65 years of age or older, and more than one-half of all veterans have passed their 47th birthday.

The magnitude of our activity is indicated by the fact that currently the VA provides all or part of the income of more than 1.6 million persons age 65 and over. Also, on a "typical" day in the VA-supported inpatient facilities (i.e., hospitals, nursing homes, and domiciliaries) more than 35 percent of our inpatients, about 37,500 veterans, are age 65 and over.

I hope the enclosed information will be helpful to the committee. Please let us know if we can provide any further aid.

Sincerely,

RUFUS H. WILSON,
Deputy Administrator.

Enclosure.

1. INTRODUCTION

Aging brings with it an increase in the need for acute medical care, outpatient treatment, and many extended nonhospital modes of care such as nursing home, domiciliary, hospital based home care and day care. More VA medical program resources are going to the aging veteran. In 1980 approximately 30 percent of all of the resources—hospital, outpatient, and extended care—went to veterans who are 65 and over. In 1990 the proportion will be about 40 percent.

Extended care bridges full hospital care and independent living with a diversity of programs. The VA had about 51,000 veterans in extended care programs on a typical day in fiscal year 1980, some 45 percent of whom were 65 and over. The increasing number and diversity of extended care programs in the VA parallels that in the Nation.

The VA program for extended care and aging in the 1980's revolves around four major objectives for this area. The first is to improve the quality of care and life for patients of all ages in VA. The second is to improve the utilization of the specific VA programs and their management through lower costs associated with improved staffing, management, patient selection and by the development of alternatives to existing programs. The third is to increase the number of extended care facilities and to improve existing ones. The fourth, which cuts across all of the others, is to provide the Nation with model programs of long-term care, trained personnel in geriatrics and gerontology, and substantial amounts of research in basic and applied gerontology. Education and training are intimately involved in all of these objectives.

2. EXTENDED CARE PROGRAMS

VA NURSING HOME CARE

This program is designed for veterans who are not acutely ill or in need of hospital care, but who require skilled nursing care and related medical services. Typically, a veteran admitted to VA nursing home care is chronically ill, has a permanent or residual disability, is expected to require a long period of nursing supervision, observation and care, and requires special efforts of a long-term rehabilitative nature. All the services required for the comprehensive care of a veteran in the nursing care unit are available through the resources of the medical center. Nursing home bed increases occurred during the year through replacement of units in Columbia, S.C.; Hampton, Va.; and Miami, Fla. During 1980, there were nursing home care units at 92 VA medical centers with 8,394 average operating beds and an average daily census of 7,933. The number of patients treated was 12,750.

COMMUNITY NURSING HOME CARE

This program is designed for veterans who are not acutely ill and not in need of hospital care, but who require nursing home care and related health care services. The primary purpose of this program is to aid the veteran and his family in making the transition from a hospital to the community by providing time to marshal resources for the veteran's continuing care. Participating facilities are assessed by VA personnel prior to approval and no less than every 2 years thereafter. Followup visits are provided to the veteran in the nursing home by the hospital social worker, nurse, and other members of the treatment team. Under this program, non-service-connected veterans may be placed in community facilities at VA expense for a period not to exceed 6 months. Veterans requiring nursing home care for a service-connected condition may be placed at VA expense for as long as the nursing care need exists.

As of September 30, 1980, 2,979 nursing homes were under contract with the agency, 1,187 of which were skilled homes and 1,792 of which were intermediate care facilities or combined skilled and intermediate care facilities. A total of 28,536 veterans were served by this program during fiscal year 1980 with an average daily census of 8,529.

HOSPITAL BASED HOME CARE

This program allows for an early discharge of veterans with chronic illness to their own homes and reduces readmissions to the hospital. The family provides the necessary personal care under coordinated supervision of a hospital based multidisciplinary treatment team. The team provides the medical, nursing, social, rehabilitation, and dietetic regimens as well as the training of family members and the patient. Thirty VA medical centers are providing hospital based home care services. More acute care beds in hospitals are made available by providing increased days of care in the home.

VA DOMICILIARY CARE

The VA domiciliary program is designed to provide necessary medical treatment and comprehensive professional care for eligible ambulatory veterans in a residential-type setting. The program is directed toward those veterans who are disabled by age, disease, or injury and are in need of care, but do not require hospitalization or the skilled nursing services of a nursing home. To be entitled to domiciliary care, the veteran's disability must be chronic in nature. The veteran must also be incapacitated from earning a living and meet an income limitation criterion.

In fiscal year 1980 the 16 domiciliaries operated 9,217 (average) beds with an average daily census of 7,894. The number of patients treated was 15,180.

New program directions were implemented during the year to create a better quality of life for veterans requiring prolonged domiciliary care and to prepare veterans returning to community living for active participation in various community resources. A survey was initiated during fiscal year 1980 to obtain information about the personal characteristics of domiciliary patients. Survey data will be analyzed and a report prepared during this fiscal year and will be used to further develop and refine domiciliary policies and program directives.

The replacement domiciliary at the VA medical center in Wood, Wis., the first new domiciliary facility since 1953, was activated during fiscal year 1980. A feasibility study was approved by the Office of Management and Budget for the use of instruments to assess change in patients moving from the old to the new facility. The study was initiated and is in process.

Construction is in process on replacement domiciliary facilities at the VA medical centers in Dayton, Ohio; Bay Pines, Fla.; and Martinsburg, W. Va. Activation of these facilities is expected during fiscal year 1981.

PERSONAL CARE HOMES

This program provides personal care and supervision in a homelike setting in the community for veterans who have no homes or whose homes do not provide the care they need. The veteran pays for his care, usually out of the combination of VA pension, supplemental security income, and/or social security disability payments. All veterans with sufficient funds may utilize this service Homes vary in size from those accommodating 1 veteran in a family setting to homes accommodating 20 or more veterans. Homes are periodically inspected by an interdisciplinary team from the nearest VA hospital. Regular followup visits to the homes are made by members of the VA hospital staff. The social worker is the most frequent visitor, working with relationships between sponsor and veteran, veteran and family, and veteran and the community.

STATE HOME PROGRAM

The State home program has grown from 11 homes in 11 States in 1888 to 43 State homes (one of which has two annexes) in 31 States and the District of Columbia. Currently a total of 16,760 beds are authorized to provide hospital, nursing home, and domiciliary care. The VA relationship to State veterans' homes is based upon two grant programs. One is a per diem program which enables the VA to assist the States in providing care that meets modern standards of quality to veterans requiring domiciliary, nursing home, and hospital care. The other grant program provides VA assistance with 65 percent Federal funding in the construction of new domiciliary and nursing home care facilities, and the expansion and remodeling of existing facilities. The State home per diem program is administered through VA medical facilities which reimburse the States on a quarterly basis. The construction program is administered by central office.

Since the enactment of Public Laws 88-450 in 1964 and 91-178 in 1969, VA grants have been utilized by 31 States.

In 1980 Arkansas established its first State home consisting of 150 domiciliary beds. In addition, new construction resulted in the addition of a 75-bed nursing home at Erie, Pa.; a 51-bed domiciliary at Lisbon, N. Dak.; and an 80-bed nursing home and 10 additional domiciliary beds at Boise, Idaho. The VA also obligated funds in fiscal year 1980 totaling over $8 million in support of constructing an additional 200 nursing home care beds and 60 domiciliary beds. During fiscal year 1980, the average daily census in State veterans' homes was 5,584 nursing home care, 4,888 domiciliary, and 929 hospital patients.

GERIATRIC RESEARCH, EDUCATION, AND CLINICAL CENTERS (GRECC'S)

The GRECC program consists of eight centers and represents another aspect of the multifaceted VA response to the health care needs of aging veterans. It serves as a mechanism for attracting and developing superior staff into the field of gerontology and geriatrics. GRECC activities have been directed toward utilizing and redirecting existing resources for geriatric care and advancing into the VA system clinical research and educational achievement in geriatrics and gerontology. As a part of the program, GRECC's have been developing geriatric evaluation units, usually of 10 to 30 beds, for intensive diagnosis and therapy. Four GRECC's have instituted evaluation units with a broad base in general internal medicine.

Each center typically emphasizes one area of research relevant to aging. For example, one has developed a cardiopulmonary function evaluation unit, and three others, all with neuropsychiatric orientation, are focusing on chronic neurological diseases and organic dementias. GRECC professionals have published or presented over 300 scientific papers. GRECC centers have reported the award of $4.5 million in research funds since the beginning of the program in fiscal year 1975. Over $1.1 million was awarded from the VA through the merit review process in fiscal year 1980. Since fiscal year 1975 the GRECC's have also received awards of more than $3 million from other Federal agencies and private foundations. A formal evaluation of the GRECC program was completed in fiscal year 1980 with site visits made to all of the centers. The site visit team concluded that the GRECC's are making impressive studies in the field of geriatrics and are altering negative perceptions regarding geriatrics in their institutions and communities.

INFORMATION AND REFERRAL PROGRAM

To minimize duplication of effort and to promote efficient use of resources, the VA is actively participating in coordinative endeavors with other Federal agencies on behalf of elderly veterans to provide information and referral services.

During the past year, information and referral liaison representatives from VA medical centers and regional offices continued their liaison with the area agencies on aging (AAA's) within their various jurisdictions. Service to the AAA's is provided in varying degrees depending upon their responses to the VA offer to provide service. Many AAA's are visited regularly; all others are served on an oncall basis. Personnel from the Department of Veterans Benefits have conducted veterans benefits training seminars for AAA's intake counselors in more areas during 1980.

3. MEDICAL SERVICE

The Veterans Administration Central Office Medical Service and the medical services in Veterans Administration medical centers continued to pursue their goal of improving the overall quality of medical care provided veterans during 1980. Once again a large share of these efforts addressed the needs of the aging veterans since this group of patients constitute a significant portion of our patient population both in terms of numbers and professional challenges.

In addition to this general medical interest in the aged patient, several more specific activities in this area were carried out during 1980. The VA has developed policies and procedures for surveillance of patients who have had cardiac pacemakers implanted and a cardiac pacemaker registry has been established. A large proportion of these patients are in older age groups. Two VA medical centers are continuing to survey aging veterans with high systolic blood pressures. This survey will measure mentation in patients on and off treatment. The recently established centers for handling rheumatology-immunology and cardiopulmonary rehabilitation problems continued their growth and development during 1980 with obvious impact on the care of the aging veteran. Medical Service is also collaborating with other professional services to improve clinical nutrition care in the VA system. The potential significance of improved nutrition for aging patients in promoting better quality of life and quality of care is great. It is recognized that the aged and those with degenerative diseases associated with aging are at high risk of developing certain infections. Vaccines are available to prevent influenza and pneumococcal disease and these vaccines are offered to aged veterans in VA medical centers, OPC's, and nursing homes according to nationally accepted recommendations.

4. MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

A focus on the mental health of the aging veteran is an important facet of the VA health care program. The Veterans Administration facilities for the care of older veterans are principally in the extended care programs, the Medical Service and the Psychiatry Service. Many of the patients in the intermediate medical care and the extended care facilities have a psychiatric diagnosis as well as that of some physical disability. On a given day the Medical Service in extended hospital care has about 10,500 patients (about 50 percent of these also contain a psychiatric diagnosis). Of this group 51 percent are 65 years or over and it should also be noted that some of the extended care programs report increasing numbers of admissions for long-term medical care directly from the community and not as transfers from one of the VA medical center wards or clinics.

Of the patients with a psychiatric diagnosis who are age 65 years and older, 76 percent are on a psychiatric ward and 24 percent are on other wards, principally medicine. Many other psychiatric patients are in VA and community nursing home facilities, VA domiciliaries, and residential care homes.

The Veterans Administration supports, through its research program, research on problems in long-term psychiatric disease such as senile dementia and alcoholism, as well as other diseases common among aging individuals.

Psychogeriatric programs are conducted at the VA medical centers in both Little Rock, Ark.; Lyons, N.J.; Northport, N.Y.; and Salisbury, N.C. Many others have units specializing in psychogeriatrics. A large number of aging patients are in various types of community based care. It is believed that some of these patients will make a better adjustment in the community and many show some improvements in their physical and mental state if kept physically and mentally active. To serve some of these patients geriatric day care programs at VA medical centers in Palo Alto, Calif.; North Chicago, Ill.; Boston (outpatient clinic), Mass.; and Loma Linda, Calif. This number is expected to increase as staff and support become available.

5. Social Work Service

The development of community outreach services to an elderly high-risk veteran population received continuing emphasis in Social Work Service during fiscal year 1980. Although budgetary constraints have been and will continue to affect allocation of resources to this program area, a number of medical centers have been able to maximize the use of scarce professional resources through the initiation of interdisciplinary assessment models tasked with developing a profile of the elderly veteran who is most likely to require social work intervention as a condition of comprehensive health care planning. Factors such as income, severity of illness, and availability of family or "significant other" support systems have been critical elements in identifying those patients most in need of social assessment and discharge planning assistance.

Considerations related to quality of life of our aging veteran population have led to the initiation of intergenerational group experiences involving veterans and young people heretofore unfamiliar with the impact of major social, economic, or cultural influences on the day-to-day existence of those who experienced the events. Hours that might have been spent in superficial activities were thus utilized to enrich the lives of both teachers and students through a productive interchange of ideas between the young and old. Foster grandparent programs have emerged in selected domiciliary settings whereby title XX funds are provided veteran residents who provide companionship or other assistance to needy young people in the community. This has the effect of reducing isolation between the age groups and between the VA and community settings.

During fiscal year 1980 social workers provided placement and followup services to over 67,000 veterans in approved community settings. Approximately 4,700 veterans were placed directly from the community in VA approved nursing homes, residential care homes, and other community facilities. Over 3,100 veterans discharged from community nursing homes were assisted in returning to their homes following a period of VA approved care.

Recognizing that access to a continuum of care is essential to the medical and emotional well-being of the elderly, selected medical centers have initiated inpatient training units to prepare the at-risk elderly for reentry into community living. Such centers also provide a multidisciplinary training base for the health care disciplines through the provision of a team-oriented approach to the assessment of needs and the development of appropriate aftercare services for a patient population.

A number of American Legion posts are hosting adult day care or senior center type activities for elderly veterans in need of supportive services of a preventative and maintenance nature. In one center community agencies have been mobilized to assume a major responsibility for the continuing operation of the program which has permitted Social Work Service and other disciplines to effect a planned withdrawal from the program as primary service providers. The movement of the program from a hospital to a community base not only reduces the required investment of VA staff time but also facilitates the development of a broader base of community support for an expanding program of services to the elderly.

Long-term care patients with potential for independent living are being assisted by social workers to move from structured residential care settings to apartments where, with staff consultation, they will be in charge of their own affairs. Although movement from dependence to a more independent lifestyle requires a significant investment of social work manpower, we believe the benefits achieved in terms of improved quality of life for our older veterans will more than offset the investment required.

The development and coordination of information and referral services and the appointment of liaison staff with areawide agencies on aging at all VA medical centers have facilitated the delivery of services to older veterans. Continuing emphasis on interagency communication has encouraged the development of a more efficient network of services to meet the needs of the elderly.

6. REHABILITATION MEDICINE SERVICE

The highlight of Rehabilitation Medicine Service's (RMS) involvement in the rehabilitation of the aging veteran in fiscal year 1980 was the May conference in San Antonio, Tex., on this specific theme. A multidisciplinary mix of RMS therapists and physicians from 17 States met to assess the needs of the geriatric veteran to determine what rehabilitation expertise and programing should be incorporated in health care programs throughout the VA system. Speakers from the National Council on Aging, the University of Texas at San Antonio and the VA medical center in San Antonio, discussed attitudes, physiology of aging, and needs of this particular population. A summary report of this conference is planned for distribution to all VA health care facilities to reflect the discussions and recommendations of this conference group. VA–RMS representatives were also an active part of the Third Annual Conference on Aging and Health cosponsored by the University of Virginia School of Medicine and the VA medical center in Salem, Va. This September 1980 conference focused on "coping and caring" for the aging population in their own communities.

RMS has been actively involved in the planning of the new "degenerative and debilitating disease rehabilitation center" in Camden, N.J. Special programs in activities of daily living will be included in this facility to help focus on the needs of the aging hospitalized veteran. New initiatives being planned in Rehabilitation Medicine Service involve the creation of independent living activities programs which will be geared to making the transition between hospital and community a successful venture. Additional plans call for adding compensated work therapy (CWT) programs to the 16 VA domiciliary programs. These CWT's are work programs which involve the patient residents actually working on projects through contracts with community businesses. Further efforts are currently underway to add rehabilitation staffing to the existing VA geriatric research, education, and clinical centers (GRECC's) to utilize the skills and techniques which have previously been developed in these specialized centers.

While all of the above activities have demonstrated relatively new initiatives for RMS in geriatric care, it must be emphasized that, VA-wide, a continuum of programs are in effect and have been reported on in previous documents such as this. One medical center continues the cooperative efforts between the nursing home care program and the local elementary school class. Another center has constructed motorized "go-carts" for use by the older in-hospital patients. Many VA medical center rehabilitation medicine programs are utilizing sensory integration dysfunction techniques for the longer term population; cardiopulmonary and rheumatology rehabilitation programs, and amputee rehabilitation techniques. Physical conditioning and fitness routines for the elderly inpatient have been both beneficial to the patient as well as for nursing staff since exercise oftentimes reduces or delays total bed care needs.

Rehabilitation Medicine Service is committed to becoming even further involved in the planning and implementing of future rehabilitation and followup programs for the geriatric population in the VA health care system. Hopefully, these programs can be used as models for the entire Nation to follow or duplicate in the years ahead.

7. NURSING SERVICE

Nursing care to the elderly veteran is a critical part of the Nursing Service mission and is viewed as comprising the majority of the health services required by this age group. Throughout the year, workshops have been held at five regional medical education centers (RMEC's) to involve nurses from field stations in implementation of the standards of gerontologic nursing care. From these educational efforts, a goal of higher quality nursing care for the aged veteran is anticipated. Nurses have also participated as faculty and participants in RMEC seminars on clinical aspects of aging whenever they could be released from duty. Additional educational efforts are needed, but travel and educational funds for our nursing services are severely limited.

The need for improved community services to the aged veteran and his family still exists, as does the need for preventive care programs. The heavy involvement of nurse practitioner in ambulatory care and in the hospital based home care programs of the VA have helped to meet these needs, but these programs only scratch the surface. Nurses in the Sepulveda and Little Rock VA Geriatric Research, Education, and Clinical Centers (GRECC's) have engineered relationships with local colleges of nursing for multidisciplinary team training in gerontology funded through the VA or the local university. The Wadsworth and Little Rock VA GRECC's accept masters and baccalaureate nursing students on their clinical units. It is hoped that these educational efforts with young students of all the health professions will enhance the ability of the VA to recruit qualified personnel for care of older veterans.

Nursing Service input was requested and given to the Department of Health and Human Services via the American Nurses Association in establishing the "Guidelines for Skilled Nursing and Intermediate Care Facilities." In addition, Nursing Service is responsible for identification of qualified nurses for the centralized position of supervisor, nursing home care unit. With the construction of new 200-bed nursing home care units, this position becomes as complex as the chief nurse position in some of our smaller hospitals. Executive development training for this group of nurses is a primary goal.

During this fiscal year, Nursing Service recruited and transferred to central office a full-time staff member with program responsibility for gerontologic and geriatric nursing concerns. Since August, this staff member has worked with Extended Care, Rehabilitation, Professional Services, Research, and Academic Affairs at central office to implement title III of Public Law 96-330 and to plan activities to enhance care to older veterans. This employee also testified at Senator Pryor's hearing on "Mental Health Needs of the Elderly" and was a delegate to the White House Miniconference on Mental Health in Aging. Numerous informal consultations have been offered to field stations and individual nurses. Site visits to the geriatric research, education, and clinical centers (GRECC's), as funds permit, have served as a management strategy to increase nursing contributions to these vital centers. Local universities are beginning to request services from this staff member as an occasional consultant or workshop faculty member. These efforts will enhance the ability of Nursing Service to recruit qualified nurses for positions in the VA and to share with others the innovations and programs for care of the elderly currently in progress or under development.

8. DIETETIC SERVICE

Nutrition is one facet of health care that impacts daily on the quality of life of older veterans in acute care, extended care, and community care settings. Qualified dietitians assure the accuracy of the prescribed diet provided for aged veterans in VA medical centers. These prescribed diets are translated into foods that are appealing and acceptable to the preference and physical limitations of older veterans and that are not contraindicated by their prescribed medications. Dietitians closely observe the eating habits and food consumed at mealtime by older veterans to assure their intake of a nutritionally adequate diet. The aging process and disease contribute directly to malnutrition. Therefore, dietitians in VA medical centers are particularly vigilant of older veterans' nutritional status. Nursing home care units and domiciliaries, where the resident population is largely older veterans, have dining areas where veterans take their meals rather than receiving a tray at bedside. The stimulation of social interaction at mealtime serves as a positive influence on these veterans' mental attitude and desire to eat.

In coordination with other members of the health team, dietitians help to prepare aged veterans to return to the community. Since many in this age group now live alone, nutrition education is an essential component of discharge planning, particularly for those on fixed incomes trying to cope with an inflationary economy. Meal planning, food budgeting, purchasing, and preparation, and selecting nutritious meals from restaurant menus are included in the counseling given by dietitians. The dietitians' followup in the community for aged veterans in the hospital based home care program and residential care program assures continuity of nutritional care. Family members, caregivers, and community home sponsors are also counseled concerning aged veterans' nutritional care needs to enable them to provide appropriate support.

There is much more to be learned about nutrition in aging. The changes in the older persons' capacity to use nutrients must be researched in order to determine the impact of nutrition in delaying the aging process and preventing the onset of degenerative diseases. As resources become available, dietitians must work with medical investigators to study the nutrition problems that are deteriorating the quality of life for the aged, the very population which is growing most rapidly among the entire country as well as among veterans.

9. VOLUNTARY SERVICE

The continuing commitment of older citizens to their volunteer involvement in Veterans Administration medical facilities was demonstrated dramatically in the 50th anniversary year of the agency. Twelve VA volunteers who have served veteran patients for 50 years or more and are still usefully active were located and received letters of appreciation from President Carter in April 1980. Their individual volunteer service records ranged as high as 67 years and their cumulative total of active involvement was nearly 700 years.

Another statistic useful in defining the commitment of the older volunteers in the average of 40 awards earned each year by the volunteers whose cumulative service has reached 20,000 hours.

These men and women are outstanding examples of thousands of older citizens whose volunteer work in the medical centers contributes to their physical, emotional, and mental well-being. Among the patient and family contact areas which these volunteers find most appealing are escorting patients between wards, clinics, and recreation areas, providing coffee, information, and reassurance to patients and families in admission areas and surgery waiting rooms. Because the already popular escort service has the added advantage of freeing professional and paraprofessional staff for other essential duties, the VA is encouraging its expansion.

The other aspect of VA volunteer involvement with older citizens follows naturally from the rising age level of the average veteran patient. The number of medical facilities with volunteers visiting elderly VA patients in community nursing homes continues to grow. In addition, volunteers are very positively involved in the palliative care, or hospice, programs for terminally ill patients. These carefully selected and trained volunteers are completely assimilated into the medical care teams whose mission is to ease the final weeks and days of the patients, many of them elderly, and lend support to their families.

10. DENTISTRY

In recognition of the ever increasing commitment that the Veterans Administration has in care of the aging, the Office of Dentistry has continued its emphasis on the preparation of VA dentists for their role in this effort.

As the direct result of an earlier workshop in geriatric dentistry held at VA Central Office in Washington, a needs assessment questionnaire has been developed to provide guidance for future education and training of VA dentists and auxiliary personnel in gerontology and care of the geriatric patient. Because of the overlap in interest and function, this thrust is going forth as a cooperative effort of the Offices of Dentistry, Extended Care, and Academic Affairs. The needs assessment instrument is currently being evaluated by selected consultants from outside the VA system.

Geriatric dentistry and dentistry's role in the care of the geriatric patient were agenda items and received special emphasis at a conference of 98 chiefs of Dental Service held in April 1980.

For a number of years dentists at the Boston VA Outpatient Clinic have been active participants in a long-term, nationwide normative aging study related to age changes in oral health and function. Two of these dentists were principal editors of a recently published book on geriatric dentistry that has received considerable attention and praise from gerontologists and members of the dental profession.

11. MEDICAL RESEARCH SERVICE

In 1976 23 million people in the United States (11 percent of the population) were 65 years of age or older, and this number is expected to reach 32 million (14 percent) in the year 2000 and perhaps 45–55 million (20–24 percent) by the year 2020. Moreover, the most rapid growth is expected to be among the extremely aged; that is, in the year 2000 there will be approximately 17 million individuals age 75 and over and 5 million who will be age 85 or older. This marked increase in the proportion of the aged in the population threatens to seriously weaken our capacity to provide care for the elderly through the traditional medical and social systems and, thus, necessitates the development of new methods of health maintenance and social support.

Research on both the medical and psychosocial problems of the elderly are required if the health and social welfare costs generated by this segment of the population are to be reduced. That is, if the physical and mental defects caused by disease in the aged are diminished, the need for medical and social services will be decreased, and if the socioeconomic status of the elderly is maintained at acceptable levels it may be possible to prevent, stabilize, or partially reverse functional impairments frequently encountered in the aged, again lessening the need for government supported medical and social intervention.

The Veterans Administration has long emphasized the health and social needs of the aging veteran and, as a result, has given strong support to research on the biological, clinical, and psychosocial aspects of aging. These efforts have been manifested in the assignment of high priorities to research on the biology of aging and the development of innovative health care delivery systems. Some results of this research are as follows:

BASIC SCIENCE STUDIES

In the San Francisco VAMC antibodies to normal tissue components are found not uncommonly in the sera of elderly humans. Work with strains of mice which develop similar antibodies has revealed abnormalities of antibody forming cells, immune regulatory cells, scavenger cells, and deficiencies in thymic hormones which, in part, control immune responsiveness. It has also been found that male hormones suppress auto-antibody formation and estrogens enhance antibody formation.

In the San Diego VAMC a marked defect in the maturation of antibody-forming cells has been found in elderly humans.

At the Bedford VAMC an aged-related decrease in the number of dendrite spines (nerve input terminals) was demonstrated in rat brain Basket cells; no changes were noted in Purkinje cells. An aged-related increase in brain-reactive antibodies was found in both the mouse and monkey. The decreased ability of cells from old animals to synthesize new proteins has been found to be due, in part, to a decrease in the proportion of active assembly units, the ribosomes. Chemical studies on lipofuscin, a pigment found in the brains of humans with senile dementia, have shown no changes in proteolipid or basic protein content, but lipid analysis has increased amounts of p-ethanolamine, p-inositides and p-choline.

At the St. Louis VAMC aged rats were found to respond abnormally to calcium deprivation, to a large degree because of their diminished capacity to form the most active vitamin D molecule (i.e., to hydroxylate 25-hydrooxycholecalciferol).

At the Audi Murphy VAMC food restriction markedly increased the median life span of male rats and delayed the age-related increase in the serum concentrations of free fatty acid and cholesterol.

At the Shreveport VAMC the levels of two catecholamine neurotransmitters were found to be diminished in several areas of the brain in middle aged and old rats.

At Bay Pines VAMC the ability of the fruit fly to survive a standard stress was shown to diminish with age, and this was associated with a disorganization of certain temporarily controlled biological activities. Similar results were found in mice.

At the Long Beach VAMC the absorption of vitamin A was found to increase significantly with age in the rat, raising the possibility of similar changes in absorption of other fat soluable nutrients and drugs in the aged human.

At the Ann Arbor VAMC protein synthesis in the salivary glands of old rats was found to be 30 percent less than in young animals.

At the Sepulveda VAMC the frequency of an abnormal form of mitochondrial DNA was found to increase with age in two strains of mice and one rat strain; the highest concentrations were found in the brains of mice and the kidneys of the rat. Studies have demonstrated the appearance of abnormal accumulations of catecholamine neurotransmitters in the brains of old mice. An age-related decrease in myocardial responsiveness to catecholamine stimulation has been shown in the rat; this is thought to be due, in part, to a decrease in total and catecholamine-sensitive adenylate cyclase (second messenger systems).

At the Wadsworth VAMC regeneration of subsets of T-cells following sublethal irradiation is delayed and the pattern abnormal in middle aged and old mice. Loss of immunological vigor in old animals has been correlated with thymic involution. Chronic viral infection has been found to accelerate immunologic aging. A protein which binds IgG auto-antibodies has been detected on the membranes of old red blood cells, and it has been postulated that the binding of the IgG by this protein triggers selective destruction of old red cells. A simple chemical, 2-mercaptoethanol, has been found effective in restoring impaired immune function in old mice. The bone loss seen in old mice can be prevented or partially reversed by transplants of young bone marrow cells. An age-related loss of marrow stem cells has been demonstrated in mice, and the cellular systems which regulate the rate and pattern of differentiation of these blood cell precursors were shown to be impaired. The maturation of antibody forming cells has been found to be impeded in old mice, in part secondary to impaired T-cell function.

At the Palo Alto VAMC glucose tolerance was shown to deteriorate with age in rats, and this was associated with an increase in circulating insulin. Resistance to the effects of insulin did not appear to increase with age in nonobese men. Plasma triglyceride levels increased with age in rats of both sexes, and this appeared to be caused by an age-related defect in the removal of the triglycerides from the blood. Pancreatic insulin was found to increase with age in the rat; however, the amount secreted following a standard stimulus decreased, perhaps because of a decrease in islet cell cAMP.

CLINICAL STUDIES

At the Minneapolis VAMC it was found that 38 percent of a group of demented elderly patients had potentially reversible causes for their intellectual deterioration; of these, approximately 50 percent improved with treatment. Studies on Parkinson's disease have provided evidence that the muscular rigidity is the result of disordered control in a particular long loop reflex pathway. This finding may provide a basis for more specific therapy of this disease.

At the Boston VA OPC cognitive functioning of the older patient was enhanced by increasing their perception of control with respect to their performance on learning tests. That is, perceived control increases motivation to learn and remember. Cross sectional and longitudinal studies indicated that there is relatively little age-related decline in short-term memory. However, a dramatic decline with age was demonstrated in the acquisition and retrieval of new information from long-term memory. Older patients who have functional memory disorders (not on an organic basis) were found to have difficulties with both motivation and distractibility.

At the Palo Alto VAMC long-term memory improved in six elderly subjects who were given very low doses of physostigmine intravenously in a double blind crossover study. Two other drugs appeared to have no effect on long-term memory.

At the American Lake VAMC normal elderly subjects were found to have mild disturbances of their sleep patterns similar to those observed in senile dementia of the Alzheimer's type.

At the St. Louis VAMC a cardiopulmonary rehabilitation program has drastically reduced hospitalization time for elderly patients with heart and lung disease. Other studies have suggested that anitcoagulation therapy in the acute phase of myocardial infarcation is not beneficial in reducing clot formation.

At the Sepulveda VAMC it has been found that older individuals have more difficulties in tasks requiring recurrent recognition or reproduction of visual or tactual designs but not of auditory patterns.

At the San Francisco VAMC EEG sleep studies performed on normal elderly subjects showed that age per se affects many aspects of brain wave activity. About 10 percent of this apparently normally functioning group was found to have on CAT scan (computer analyzed X-ray studies) a degree of brain atrophy consistent, by present criteria, with that found in dementia.

PSYCHOSOCIAL STUDIES

At the Miami VAMC self-assessed health was found to be more favorable in a group of elderly individuals expressing internal control of their life situation, and more restraints such as poor eyesight, loss of hearing, problems of memory, and needs for outside support were associated with those elderly who were controlled more by external factors. Since self-assessed health relates to level of functioning and to the way the elderly react to an illness, it can be a useful component in evaluation and a means by which behavior can be modified.

At the Columbia VAMC compensatory physiological changes were greater in elderly than in young subjects required to adapt to stresses of psychosocial testing.

At the Buffalo VAMC it was found that, contrary to conventional wisdom, an institution may provide an environment that facilitates and nourishes the self-esteem and satisfaction of a subset of the elderly (male VA domiciliary members).

12. EDUCATION

The Office of Academic Affairs continues to emphasize leadership in education and training in geriatrics throughout the Department of Medicine and Surgery. The importance of geriatric education is recognized each day in the increasing number of older veterans seeking care in VA medical centers.

In cooperation with the Offices of Extended Care and Professional Services, the thrust of the educational strategies has been directed toward health care providers, and has emanated from various VA resources, i.e., VA central office (VACO); regional medical education centers (RMEC's); geriatric research, education, and clinical centers (GRECC's); and individual health care facilities. On a continuing cooperative basis these facilities offer training programs which address the multifaceted aspects in the professional and paraprofessional care of the elderly.

SEMINARS ON AGING

Annual national seminars on aging were initiated 5 years ago for D.M. & S. personnel including physicians, nurses, social workers, psychologists, and other therapists. An interdisciplinary approach has thus been incorporated into the educational design. Subsequent to the annual seminar participants develop proposals for educational program efforts to be conducted during the year in their respective facilities.

MANPOWER GRANTS PROGRAM (PUBLIC LAW 541)

The manpower grants program, VA Medical School Assistance and Health Manpower Training Act of 1972, has awarded several grants to academic institutions in support of training in a variety of aspects of geriatrics. These include long-term nursing care of the aging adult, nurse practitioners in geriatric settings, and interdisciplinary training for various types of geriatric services.

PHYSICIAN GERIATRIC FELLOWSHIP PROGRAM

Thirty-two physicians are now enrolled in the geriatric fellowship program which is designed to develop clinical excellence in geriatric/gerontology for inpatient, ambulatory, and long-term care settings. The training program is 2 years in length. Physicians who are board eligible or certified in internal medicine, family practice, psychiatry, or neurology are eligible to apply. Six fellows have participated in a 4-month international experience at a geriatric center in the United Kingdom (St. Pancras Hospital, London; University of Manchester, Manchester and City Hospital, Edinburg). In cooperation with the Office of Research and Development, plans have been developed for a selected group of geriatric fellows to compete for an associate investigator award. This award will provide an additional year of research training in geriatric medicine.

Under a contract to the University of California, Los Angeles, School of Medicine, an education program guide for geriatric medicine is in the final stages of development. The guide will include selected bibliographic references of print and nonprint learning resources and a compendium of behavioral objectives for geriatric medicine. The guide will augment the curriculum materials available to the program directors, fellows, and faculty in affiliated medical schools.

In June 1980, the first group of eight fellows completed their geriatric training. Three are employed in VA medical centers and two are serving as consultants to the VA.

The geriatric fellowship program is conducted at 12 VA medical centers located at Bedford, Mass.; Buffalo, N.Y.; Durham, N.C.; Gainesville, Fla.; Lexington, Ky.; Little Rock, Ark.; Los Angeles (Wadsworth), Calif.; Madison, Wis.; Palo Alto, Calif.; Philadelphia, Pa.; Portland, Oreg.; and Sepulveda, Calif.

INTERDISCIPLINARY TEAM TRAINING PROGRAM

Planning continues for the training of other health professionals in all aspects of gerontology and geriatrics. Three additional VA medical centers have been designated as training sites for interdisciplinary team training activities in geriatrics for VA staff and health professional students from affiliated colleges and universities: Little Rock, Ark.; Palo Alto, Calif.; and Salt Lake City, Utah. The previously designated sites were Portland, Oreg., and Sepulveda, Calif. This educational effort is based on the concept that health care delivered by a team of health professionals holds promise of more efficient utilization of health personnel and results in better management of elderly patients in need of continuing care. A coordinator directs the educational activity at each site.

The purposes of the team training program are to develop a cadre of health practitioners with the knowledge and competencies required to provide interdisciplinary team care to meet the wide spectrum of health-care and service needs of the aged veteran; to provide role models for affiliating students in medical and associated health disciplines; and to provide leadership in interdisciplinary team training for other VA medical centers.

Interdisciplinary team training includes teaching of students and staff about the aging process, instruction in team teaching and group process skills to clinical core staff, and clinical experience in team care for affiliating students with the core team serving as role models.

CLINICAL NURSE, SPECIALIST PROGRAM

A program was initiated in fiscal year 1980 to fund clinical nurse specialist students who receive their clinical training at VA centers. Sixty-four trainee positions will be supported in fiscal year 1981 in three VA priority areas: geriatrics (22), rehabilitation (11), and mental health (31). The clinical training in geriatrics will take place at 15 VA medical centers through academic affiliations with 13 accredited schools of nursing. The nurse specialist training in rehabilitation and mental health will also impact on geriatrics as most elderly patients have need of rehabilitation and mental health services.

CONTINUING EDUCATION PROGRAMS

Continuing education and staff development programs are also directed to geriatric training. Under the sponsorship of central office units and the seven regional medical education centers a large number of workshops and conferences on the subject of geriatrics and gerontology are conducted each year for the staff of VA medical centers, outpatient clinics, nursing homes, and domiciliaries. In fiscal year 1980 programing consisted of approximately 40 different training activities. Examples of subjects included: Rehabilitation of geriatric veterans; geriatric medicine; chronic illness in aging—the social work role; geriatric assessment; clinical geriatrics; VA nursing home care; new directors for domiciliaries; the aging veteran; implementing gerontological nursing standards; personal care homes; and many others. Funds are also used to support continuing education at geriatric research, education, and clinical centers through visitation and lectureships.

LEARNING RESOURCES

This widespread education and training activity in geriatrics has generated a broad spectrum of requirements for learning resources throughout the VA system. Hundreds of online searches of automated bibliographic data bases were performed on all aspects of aging. Library collections at the GRECC's were strengthened to meet research and education needs in geriatrics and gerontology. Thirty copies each of six commercially produced videotapes dealing with the problems of aging were made available to the system through placement in designated medical district software delivery libraries and a videotape production on the VA domiciliary program was initiated at the St. Louis VA Medical Center.

13. DEPARTMENT OF VETERANS BENEFITS

COMPENSATION AND PENSION PROGRAMS

Disability and survivor benefits (pension, compensation, and dependency, and indemnity compensation) administered by the Department of Veterans Benefits provide all or part of the income for 1,604,821 persons age 65 or older. This total includes 816,985 veterans, 679,033 widows, 88,545 mothers, and 20,258 fathers. Approximately 115,598 veterans age 78 or older receive a 25-percent differential in addition to their pension benefits under Public Law 86-211, as amended.

The Veterans' and Survivors' Pension Improvement Act of 1978, effectiv January 1, 1979, provides for a restructured pension program. Under this program eligible veterans will receive a level of support meeting the national standard of need. Pensioners will generally receive benefits equal to the difference between their annual income from all other sources and the appropriate income standard.

This act provides for a $1,006 increase in the applicable income standard for veterans of World War I or the Mexican Border Period. This provision is in acknowledgment of the special needs of our older veterans.

Pensioners receiving benefits under the prior program have the opportunity to elect to receive benefits under this new program.

VETERANS ASSISTANCE SERVICE

Veterans Assistance personnel provided updated information on VA benefits and services to over 600 area agencies on aging (AAA) during fiscal year 1980 Contacts were made by telephone, letter, and in many cases, by personal visits by VA employees to conduct benefit briefings for AAA personnel. VA services to senior centers, nursing homes, and other organizations in the aging community included group discussions with administrators to help them identify potential VA beneficiaries for referral to the VA, and personal interviews with veterans their dependents and survivors during onsite visits.

A new VA pamphlet, "Veterans Benefits for Older Americans," that highlights VA benefits and services most frequently used by elderly beneficiaries was developed during 1980. It will be widely distributed by Veterans Services Division personnel during outreach visits to the aging community.

EDUCATIONAL ASSISTANCE

There are roughly 320 people age 65 or older receiving VA educational benefits of whom 220 are training under chapter 34, the Veterans Readjustment Act of 1966, as amended. Widows of veterans who died of service-connected causes, and wives of veterans who are permanently and totally disabled from service-connected disabilities total about 100 of the enrollees in the survivors' and dependents' educational assistance program. Last year there were some 30 veterans 65 years of age or older participating in the vocational rehabilitation program. While no education service and no vocational rehabilitation and counseling service programs are specifically designed as a service to the aged, participation in the programs continues to include a small number of aged veterans and eligible dependents.